Department of Community and Human Services
Veterans and Human Services Levy

2011 Evaluation and Performance Report

October 2011

Veterans and Human Services Levy
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2006 - 2011

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Veterans and Human Services Levy
2011 Evaluation and Performance Report
Table of Contents

Executive Summary
Veterans and Human Services Levy
2011 Evaluation and Performance Report

The King County Veterans and Human Services (VHS) Levy represents a commitment by the voters of King County to address the human services needs of vulnerable individuals and families, including and especially veterans and their families, for whom 50 percent of the levy proceeds are dedicated. Evaluating levy-funded activities and demonstrating results has been a priority throughout all planning and implementation. The levy evaluation efforts began with initial program designs and have continued with annual data analysis. In 2010, a Mid-point Evaluation and Performance Report was developed evaluating levy performance and accomplishments through 2009. This 2011 Evaluation and Performance Report is an update on the performance of all levy-funded activities from inception through December 31, 2010. Levy evaluation will continue through 2012 with additional reports as data from program services becomes available.

The purpose of this report has been to provide a compilation of the performance review and evaluations of all levy-funded activities implemented by December 31, 2010. The individual evaluations, summaries and charts have been used throughout 2011 as part of planning for the levy renewal – which was approved by King County voters in August 2011. The evaluation summaries have also been used in developing the 2012 VHS Levy Service Improvement Plan.

Through 2010, 40 distinct activities and sub-activities were initiated and were evaluated during 2011. The 40 evaluation reports were prepared by levy evaluation staff, contractors, and program managers. These activity-specific evaluations formed the building blocks for assessing progress toward meeting the overall goals of the levy. This VHS Levy 2011 Evaluation and Performance Report includes an overview and indicators of progress toward meeting the overall goals of the levy, as well as a summary of activity accomplishments by strategy area, and the individual activity evaluations.

Progress Toward Meeting Overall Goals of the Levy

All of the activities within the five strategic investment areas are intended to support one or more of three overall goals: (1) reducing homelessness; (2) reducing emergency medical and criminal justice involvement; and (3) increasing self-sufficiency both for veterans and military personnel in need and their families, and for other individuals and families in need. Many indicators demonstrate the levy is making progress toward these three goals:

Goal 1: reducing homelessness

- Over 2,500 isolated, chronically homeless individuals have enrolled or engaged in levy-funded outreach services as a first milestone in ending their homelessness. Approximately 18 percent of them are veterans and at least 100 clients had been involved in the criminal justice system due to mental illness or co-occurring disorders.
- Over 1,900 formerly homeless individuals are successfully maintaining their permanent housing through levy-funded services. Overwhelming evidence is demonstrating significant reduction and in many cases complete cessation of inappropriate use of emergency medical, sobering services, or incarceration for these clients.
- Affordable housing has expanded with 1,226 new permanent housing units created (or soon to come online) to serve formerly homeless persons, including 178 units dedicated to serving homeless veterans. In addition, over 105 landlords (including 62 landlords who had not rented to formerly homeless persons) are now making their existing units available to formerly homeless people through the Landlord Liaison Project.

- Homelessness has been prevented for 551 veteran and 1,350 non-veteran households who were at-risk of losing their housing. These households received short-term financial assistance that helped them handle an immediate crisis, and enabled them to retain their housing. Ninety-three percent of those who received this assistance were still in their housing six months later.

Goal 2: reducing emergency medical and criminal justice system involvement

- The levy expanded services to an additional 419 veterans served through the Veterans Incarcerated Program, saving approximately 5,500 jail days through early release.
- Over 100 homeless mentally ill clients involved in King County Mental Health Court are moving toward housing stability, and diminished justice system involvement through levy-funded comprehensive services.
- Through levy resources, parents involved with the justice system have received intensive treatment and services that have helped them reunite with and/or create healthy relationships with their children.

Goal 3: increasing self-sufficiency both for veterans and military personnel in need and their families, and for other individuals and families in need

- The King County Veterans Program (KCVP) expanded six existing programs and added one new program to serve military personnel, veterans and their families. These programs served nearly 13,000 clients and provided access to a greater range of services, including financial assistance, Post Traumatic Stress Disorder (PTSD) counseling, housing referral, and Veterans Administration (VA) benefits assistance, among others.
- The new levy-funded National Guard Family Services Program served 439 veterans, National Guard members, or their family members throughout King County, and 75 percent of those assessed demonstrated increased household stability after services.
- Close to 650 veterans who experience PTSD received 9,500 additional hours of counseling through 2010, with a demonstrated success rate of 95 percent of clients reducing PTSD symptoms.
- Over $2,100,000 in direct financial assistance from the levy was provided to over 8,600 clients to help resolve immediate financial crises.
- Over 9,762 low-income persons received treatment for depression or anxiety symptoms by the end of 2010. Close to 45 percent (including an estimated 150 veterans or their family members) successfully reduced their depression or anxiety symptoms, thereby improving their long-term health prospects.
- Over 6,900 mothers were screened for maternal depression, and 1,479 have received behavioral health treatment services that contribute to the healthy development of their children. Of those measured, 64 percent have reduced depression and/or anxiety, improving the likelihood of their successful parenting and improved self-sufficiency.
- Over 14,390 new parents have increased their education and support to ensure they get the resources and skills they need to raise healthy children.

Additional Observations

This evaluation makes several additional general observations that may help inform future levy planning and any mid-course corrections.

- The levy's services have been distributed throughout King County with significant increases in services in areas with vulnerable populations of veterans and families, especially South King County.

- There has been a significant increase in attention to veterans' needs and capability to serve veterans throughout the King County human services system. Agencies have begun tracking their clients for veteran status, and many that have not traditionally engaged veterans have now developed specialized outreach techniques, as well as new service approaches, to meet the needs of veterans and their family members.
- The levy's emphasis on implementing evidence-based practice models has been successful, as new levy-funded programs replicate success in addressing complex client needs.
- Demand for levy-funded human services programs (non-veteran) remains high.
- Levy activities that expanded existing programs were able to get underway more quickly than activities requiring creation of new programs.

Summary

In sum, the levy activities overall are meeting the three main goals established by the Metropolitan King County Council, and are having positive impacts on the lives of many veterans and others in need. The 40+ different activities contribute to these goals in different ways and to varying degrees. Evaluations of the individual activities, grouped by five different investment strategies, make up the bulk of this report.

Introduction and Overview

The voter-approved 2005 VHS Levy represents a commitment by the voters of King County to meet the human services needs of vulnerable people, including and especially veterans and their families. King County has committed to use levy resources wisely and to ensure that these resources are as effective as possible in meeting planned goals and objectives. Evaluating levy-funded activities and demonstrating results have been a paramount theme throughout all planning and implementation.

The purpose of the VHS Levy 2011 Evaluation and Performance Report is to provide a compilation of the performance of all levy-funded activities implemented by December 31, 2010. This report will support levy renewal planning and program improvements, and communicate results to the citizens of King County.

The VHS Levy 2011 Evaluation and Performance Report is a report on intermediate outcomes and levy impacts based upon the evaluation of 40 separate levy-funded activities initiated by December 2010.

Levy Overview and Strategies

The VHS Levy is a property tax that was passed in November 2005 by the voters of King County to be collected from April 2006 through December 2011. Levy tax revenues are split equally between services for veterans and their families (Veterans Levy); and services for other vulnerable persons and families (Human Services Levy).

The Metropolitan King County Council adopted Ordinance 15406 in April 2006 to guide levy planning, implementation, and design. The council established three overall goals for the levy: (1) reducing homelessness, (2) reducing emergency medical and criminal justice involvement, and (3) increasing self-sufficiency both for veterans and military personnel and their families, and for others in need. The ordinance called for development of a Service Improvement Plan (SIP), which was adopted in October 2006. The SIP identified the policy framework, priority services and populations, and five overarching strategies listed below through which the overall goals would be supported.

Strategy 1: Enhancing Services and Access for Veterans, Military Personnel, and their Families

Strategy 2: Ending homelessness through outreach, prevention, permanent supportive housing, and employment

Strategy 3: Increasing access to behavioral health services

Strategy 4: Strengthening families at risk

Strategy 5: Increasing the effectiveness of resource management and evaluation

Each overarching strategy includes a number of specific levy-funded activities that help meet the strategy's objectives.

Performance Measurement and Evaluation

Levy performance measurement and evaluation was initiated in Ordinance 15406 and the subsequent SIP. These documents direct that outcome evaluation techniques be used to assess the implementation of the levy and demonstrate the long-term results of levy investments. Levy evaluation efforts are intended to:

- Demonstrate the impact and benefits of levy-funded efforts
- Increase our understanding of successful programs and strategies
- Provide insight on process and priorities for policy makers and the community to guide future efforts.

A logical framework linking each levy-funded activity to the overall levy goals was first developed. The measurement strategies have been defined and guided based on this 2007 Evaluation Framework. The 2008 Evaluation Work Plan and the continually updated VHS Levy Evaluation Matrix further defined performance measures for each levy-funded activity. In 2010, the VHS Levy Mid-Point Evaluation was published presenting the Levy accomplishments and lessons learned for all 40 activities implemented through 2009.

2011 Evaluation and Performance Report

This 2011 Evaluation and Performance Report aggregates the results of performance evaluations from all levy activities implemented through December 31, 2010. There are four sections to the report – one for each strategy roll-up for strategies 1 through 4 (Note: Strategy 5 activities involved regional coordination and infrastructure and did not report performance in the same manner as service delivery programs funded under Strategies 1- 4)

The 2011 Evaluation and Performance Report built upon the work that resulted in the 2010 VHS Levy Mid-Point Evaluation and Performance Report. Evaluation staff expanded the scope of the review and developed evaluations and performance summaries of each implemented activity from initial date of services through December 31, 2010. Each evaluation provides a status report on the resources used, services provided, people affected, near-term outcomes, results achieved, and lessons learned. Evaluation staff worked with coordinators, contract monitors and agencies to develop these reports between January 2011 and July 2011.

This report is presented in four sections:

Strategy 1: Enhancing Services and Access for Veterans, Military Personnel, and Their Families.

Overview of the strategy evaluation findings and accomplishments and 15 activity specific evaluation reports.

Strategy 2: Ending Homelessness Through Outreach, Prevention, Permanent Supportive Housing, and Employment

Overview of the strategy evaluation findings and accomplishments and 14 activity specific evaluation reports

Strategy 3: Increasing Access to Behavioral Health Services

Overview of the strategy evaluation findings and accomplishments and 4 activity specific evaluation reports

Strategy 4: Strengthening Families at Risk

Overview of the strategy evaluation findings and accomplishments and eight activity specific evaluation reports

Strategy 1 Overview
Enhancing Services and Access for Veterans, Military Personnel, and their Families

Objective: Improve the lives of vulnerable King County veterans and their families by helping them attain and sustain a stable, successful life.

Strategy overview: King County is home to at least 131,000 men and women who are current or former active duty members of the U.S. Military, Reserves, and National Guard, and an additional 13,000 National Guard and reservists who have not yet been activated. Five overarching strategies were developed to guide use of levy funds. Strategy 1 is dedicated exclusively to helping veterans and their families. Resources have been allocated to four objectives within that strategy, with a number of activities designed to meet the strategy's objectives:

Expand the Geographic Range of the King County Veterans Program

- Expand geographic range of KCVP (Satellite Sites)
- Consultation and resources for school staff serving military children
- Outreach to special populations
- U.S. National Guard family assistance coordinator.

Increase the Capacity of the King County Veterans Program

- Increase capacity of the KCVP financial services
- Increase capacity of the KCVP for additional shelter beds
- Housing planner to increase capacity and number of housing units for veterans
- Contracted PTSD treatment for veterans and their families
- Veterans Incarcerated Program
- Homeless Veterans Reintegration Project
- Veterans Legal Assistance Project
- Employment, outreach and case management in South and East King County
- Veterans Conservation Corps Program

Provide Phone Resources for Veterans

Provide Training and Information on Veterans Administration Linkages

How have levy resources been used to meet these objectives?

Some activities within this strategy required the creation of new programs, while other activities were accomplished as expansions of existing services. Generally, expansions of existing programs were initiated more quickly while new programs took longer to design and implement. As a result, levy-funded activities were staggered in implementation. The first levy-funded services within this strategy began implementation in November 2006.Other activities initiated services from 2007 through 2010. Total expenditures for Strategy 1 through 2010 were $9,713,428 of Veterans Levy funds. Table 2-1 summarizes Strategy 1 program implementation through 2010.

Table 2-1: Strategy 1 Levy Resources Used to Date						
Activity		**Lead Implementing Agency**	**Date of First Service**	**Clients Served through 2010**	**How were levy funds used?**	**Expenditures through 2010**
Activity 1.1 Expand the geographic range of King County veterans programs						
1.1.A	Satellite sites North, East and South King County	KCVP	July 2008	**571**	Expanded new program to eight locations in suburban and rural areas	$286,392
1.1.B	Military kids curriculum development	CSD	January 2009	**32**	New curriculum developed and piloted. Now implemented in four schools.	$68,234*
1.1.C	Outreach to special populations	RFP	October 2010	**106**	New capacity	$ 0
1.1.D	U.S. National Guard family assistance coordinator	WDVA	September 2009	**439**	Financed additional outreach specialist position dedicated to King County	$84.106
Activity 1.2 Increase the capacity of King County veterans programs						
1.2.A.1	Increase KCVP financial services	KCVP	November 2006	**8,648**	Expanded financial assistance resources	$2,457,765
1.2.A.2	Increase capacity of KCVP shelter services	KCVP	December 2007	**1,114**	Contracted for additional bed nights with Compass Center and Salvation Army	$351,840
1.2.A.3	Housing planning for veterans	CSD	August 2009	**N/A**	Resources used to create a plan	$32,143*
1.2.B	PTSD treatment for veterans and their families	WDVA	April 2007	**644**	Increased contracted counseling and increased community education	$1,557,349
1.2.C	Veterans Incarcerated Project	WDVA	April 2007	**419**	Expanded staffing and added outreach services to East and South King County city jails	$412,473
1.2.D.1	Employment, outreach and case management enhancements	KCVP	September 2007	**1,898**	Expanded case management staff and implemented new model. Opened Renton service site	$3,726,679
1.2.D.2	Homeless Veterans Reintegration Project	WDVA	April 2007	**445**	Expanded project with a new veterans services manager	$336,447
1.2.D.3	Veterans Legal Assistance	NW Justice Project	September 2010	**74**	Established new program to address the civil legal needs of homeless and low income veterans	$4,000
1.2.E	Veterans Conservation Corp.	WDVA	October 2008	**283**	New program created to provide education and job development on green jobs for veterans	$291,666
Activity 1.3 Provide phone resources for veterans						
1.3.	Provide phone resources for veterans	DCHS	N/A	**231**	Contract with phone information and referral agency to be let in 2010	$108,334
Activity 1.4 Provide training and information of Veterans Administration linkages						
1.4	Increase training and linkages to VA services	CSD	N/A	N/A	To be coordinated with 1.1.C above; other activities	$0
Preliminary Total Strategy 1 clients through 2010 (duplicated)				**13,634**	**Preliminary Total $ Strategy 1**	**$9.713,428**

*2009 figures, 2010 still pending 2/4/2010

How has levy funding increased veterans' access to services?

Each Strategy 1 activity that has been implemented by 2010 has been evaluated. These evaluations are presented in detail following this summary. Levy funds have significantly expanded services to active military personnel, veterans, and their families. While each activity's accomplishments are summarized in this report, some overall intermediate outcomes demonstrate the levy's broad impact. Since 2006, $9,035,095 has been expended for Strategy 1 services to 13,634 clients. Levy-funded activities have met the following results and intermediate outcomes in 2010.

Expand geographic range of King County Veterans Program

- By 2010, the KCVP expanded to eight regularly scheduled satellite sites and conducted outreach at another 22 sites. The satellite sites served 571 clients, 51 percent of whom had never been served before. Clients have made over 1,500 visits to satellite sites since they opened. The percentage of KCVP clients served outside Seattle has grown from 30 percent in 2007 to 56 percent in 2010.
- The new levy-funded National Guard Family Services has served 439 veterans, National Guard or their family members throughout King County through 2010. Seventy-five percent of those assessed demonstrated increased household stability after services.

Increase the capacity of King County Veterans Program

- The KCVP expanded six existing programs and added four new programs serving military, veterans, and their families. These programs served nearly 13,000 clients and provided a greater range of services, including financial assistance, PTSD counseling, housing referral, VA benefits assistance, etc. The KCVP added direct service staff and now provides focused case management services to high-needs clients.
- Close to 650 veterans experiencing PTSD received over 9,500 additional hours of counseling through 2010, with a demonstrated success rate of 97 percent of clients reducing PTSD symptoms.
- Over 4,760 hours of community education and professional training were provided on veterans' disorders and related issues, increasing regional professional capacity to respond to PTSD.
- Over $2,100,000 in additional direct financial assistance was provided to over 8,600 veterans and family members to help them resolve their immediate financial crises.
- Over 800 homeless veterans received 40,000 bed nights of emergency shelter and transitional housing, thus beginning the first step of ending their homelessness.
- An additional 419 veterans were served through the Veterans Incarcerated Program since 2007, saving approximately 5,500 jail days through early release.

What lessons have been learned?

Although each activity has helped us learn very specific lessons, we have also learned some broadly applicable lessons during the first four years of levy implementation. These offer useful guidance as program adjustments are made over the next two years and considerations of levy funding renewal begin.

- Access for veterans living outside Seattle has been improved through locating services in suburban and rural areas.
- The levy has successfully increased services for family members and dependents of veterans as programs are developed that address their needs.
- Access to a broader range of services and/or benefits has been increased through establishing new service sites with cooperative relationships with other local service providers.

- More KCVP clients could benefit from case management than was initially anticipated. The enhanced assessment procedures have shown that a majority of clients face significant housing, income, and/or employment barriers. These barriers to self-sufficiency take time and coordinated services to effectively address.

Table 2-2: Strategy 1 Activities 2010 Performance

Activity		Clients Served through 2010	Services		Outcomes	
			Types	Quantity through 2010	Outcome Measures	Most recent Results
Expand the geographic range of King County veterans programs						
1.1.A	Satellite sites North, East and South King County	571	Case management contacts	1,970	New clients engaging in services	296 first-time clients
1.1.B	Military kids curriculum development	**32**	Curriculum development Curriculum testing Curriculum implemented	Developed Tested	Completion of curriculum Number of piloting schools Number of schools implementing	Curriculum complete One school piloted Four schools implementing
1.1.C	Outreach to special populations	**106**	Assistance in benefits securing benefits	65 (clients)	Clients reconnected with veterans benefits and services Percent satisfied with outreach services provided	25 clients 45%
1.1.D	National Guard Family Assistance Coordinator	**439**	Number of assessments Referrals	361 178	Increased stability	75% successful
Increase the capacity of King County veterans programs						
1.2.A.1	Increase KCVP financial services	**8,648**	Financial assistance recipients Financial assistance dollars	8,648 $2,184,167	Increased financial stability	71% measured retain housing
1.2.A.2	Increase capacity of KCVP shelter services	**1,114**	Emergency shelter bednights Transitional housing bednights	41,647 10,132	Increase housing stability	66% successful
1.2.A.3	Housing planning for veterans	**N/A**	Plan development	Developed	Increase veterans' access to housing	Plan being implemented
1.2.B	PTSD treatment for veterans and their families	**644**	Counseling hours Community education hours	9,536 4,765	Reduced PTSD symptoms	97% successful
1.2.C	Veterans Incarcerated Project	**419**	Clients screened Client enrolled Job-housing placements	419 296 168	Reduced jail days Reduced recidivism	27,570 days reduced 89% did not recidivate within year
1.2.D.1	Employment, outreach and case management enhancements	**1,898**	Client assessments Case plans developed Case contacts w/clients	2,877 683 4,317	Complete case plans Increased stability	465 case plans completed 87% increase stability
1.2.D.2	Homeless Veterans Reintegration Project	**445**	Clients screened Employment Assessments	445 345	Clients placed in housing Clients placed in jobs	129 70
1.2.D.3	Veterans Legal Assistance	74	Case reviews/assessments Training hours on veterans legal issues	74 23	Clients resolving legal issues	22
1.2.E	Veterans Conservation Corps program	**283**	Clients screened Job-training placements	324 188	Secure employment /training Job retention for one year	87% 100%
Activity 1.3 Provide phone resources for veterans						
1.3.	Provide phone resources for veterans	**231**	Number of calls received Number of callers referred	231 220	Successfully linked to services	67%

STRATEGY 1, Activity 1.1.A

Expand Geographic Range of King County Veterans Program (Satellite Sites)

Purpose / Objective: 1.1.A Expand the geographic range of the King County Veterans' Program

Activity 1.1.A Open additional King County Veterans Program service sites in the north and east King County and to link with local support services to better serve veterans, military personnel and their families living outside Seattle.

Agencies funded:

King County Veterans Program (KCVP)

Performance: July 1, 2008 – December 31, 2010

1. 571 clients served at the satellite site offices
2. 296 clients had not previously accessed KCVP services
3. 1,970 case management contacts
4. 1,505 direct client contacts on site
5. $131,119 in financial assistance

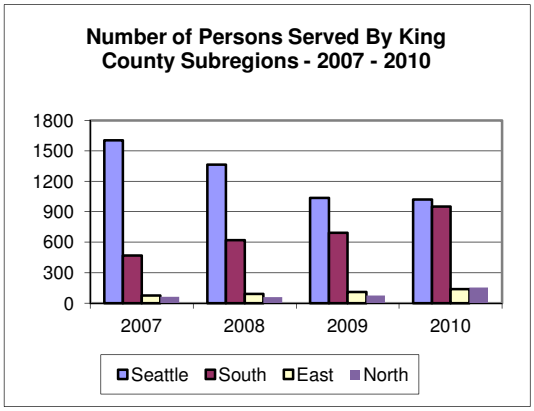
Services Start Date: July 2008

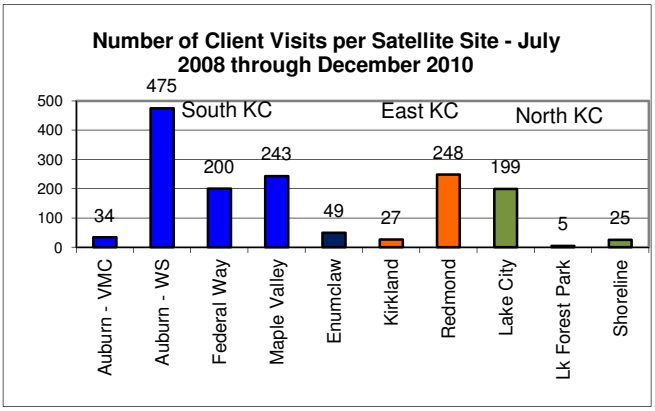
SERVICES PROVIDED

The satellite sites provide outreach, assessment, case management, service linkage and financial assistance to veterans, active military and their families. Outreach and community education are the first steps as each new satellite site is opened. Once clients are determined to be eligible for service, a full assessment is conducted to determine what services are needed. The program directly provides case management and financial assistance while referring clients to other needed services including, shelter/housing, securing benefits, counseling, medical care and substance abuse treatment.

Clients visited satellite sites 1,505 times – 2.6 visits per client. Financial assistance was the most common service – $131,119 in financial assistance was awarded to 284 clients, usually for rental/mortgage assistance, food and utility assistance. In addition, satellite site staff had 1,970 case management contacts with clients, including in-depth assessments, case management sessions, advocacy contacts, and referral consultations.

There was an increase in the proportion of persons served outside Seattle between 2007, the year before the satellite sites opened and 2010. The first bar chart below shows the steady increase in KCVP services to persons living outside of Seattle. The second chart shows the numbers served in the satellite offices since they opened mid-2008.





MOST RECENTLY MEASURED OUTCOMES

Of the 571 persons served at the satellite sites, 296 had not previously been served at the downtown Seattle or the Renton WorkSource sites.

There has been a steady increase in the numbers of persons served in the south, east and north subregions of King County since the satellite sites first opened in 2008. In 2007, only 28 percent of KCVP's clients lived outside Seattle. By 2010, that percentage was 55. The Auburn WorkSource site has been the busiest satellite site although Redmond, Maple Valley, Federal Way and Lake City also show considerable traffic.

Client Story

Susan (not her real name) is a widow of a recently deceased veteran. She was homeless, living in a Maple Valley campground. She had major medical problems with little income and no health benefits. She had no transportation to the Veterans Program's downtown Seattle or Renton offices. Satellite site staff helped her explore financial assistance benefits. They connected her to Sound Mental Health, which arranged for a primary care provider. Susan is now living in transitional housing and physically improving.

Evaluation Questions

How was the program expanded or enhanced with Levy funding?

Two full-time social workers positions have been added to staff the satellite sites. The first satellite site opened at the Auburn Veterans Memorial Building in July, 2008. The site was closed in July, 2009 and moved to WorkSource Auburn. Seven other sites were opened in June, 2009. Three North County sites were consolidated at the Community Psychiatric Clinic in January 2010. A new site at WorkSource Redmond opened about the same time. Currently, the following sites are open:

- Federal Way @ Multi-Service Center - opened June 2009
- Lake City @ Comm. Psychiatric Clinic - opened January 2010
- Enumclaw @ as of Jan 2/11 Senior Center - opened June 2009
- Kirkland @ Lake Washington Technical College – opened January 2010
- Auburn @ WorkSource Auburn – opened June 2009
- Maple Valley @ Food Bank – opened June 2009
- Redmond @ WorkSource Redmond – opened January 2010
- Carnation @ Hopelink – opened February 2010

Who has been served through this program?

Five hundred seventy one persons, including veterans and family members, have been served at satellite sites. The great majority of these were served in 2010.

Veterans served at satellites in 2010 were more likely to be female than clients served exclusively at other KCVP service sites (14% vs. 9%). Also, satellite sites deal with more married (22% vs. 11%) and divorced (26% vs. 19%) clients. Satellite site clients are less likely to be persons of color; 71 percent of satellite site clients are white compared to 51 percent of clients served elsewhere. In addition, satellite site social workers report that the rural clients they serve are more likely to be very independent and less likely to have previously accessed governmental services or benefits.

How effective have services been?

The project was effective in increasing access to veterans' services for those who live outside of Seattle. Since the satellite sites opened in mid-2008, 571 persons were served of which 296 had not previously accessed KCVP services. Site visits by clients and potential clients increased from 34 in 2008 to 203 in 2009 and to 998 in 2010, an increase of 392 percent over the past year. This kind of customer traffic meant that four out of every possible five appointment slots available at all satellite sites were filled with clients.

Are any changes in the program model anticipated?

No changes to the program model are anticipated in 2010.

Lesson Learned

1. Considerable networking with local providers is useful before opening a site in a community. This ensures that clients have access to all available resources.

2. Public education and concentrated local outreach lead to more client referrals. Many veterans in outlying areas have been unaware that satellite sites have opened locally until KCVP staff members conducted intense networking with local service providers and referral sources.
3. Satellite sites have improved access to services for veterans who live outside of Seattle. Most veterans served in outlying areas had not previously used KCVP services.

STRATEGY 1, Activity 1.1.B

Consultation and Resources for School Staff Serving Military Children

Purpose / Objective: 1.1.B Reduce the impact of service on children of military parents:

Activity 1.1.B Develop and implement a Military Kids curriculum in King County schools designed to assist youth who have been impacted by their parent's involvement in the military.

Services Start Date: January 2009

Agencies funded: Puget Sound Educational Services District – 121 (PSESD)

Performance: January 1, 2009 – December 31, 2010

1. The curriculum was completed in 2009
2. The curriculum was piloted in Renton School District
3. The curriculum was implemented in Kent, Auburn and Federal Way school districts for the 2010/2011 school year.

SERVICES PROVIDED – 2010

It is intended to help them better understand and cope with their parents' deployment and return. The curriculum is to be implemented at various middle school and high school sites in King County. The Military Kids curriculum was completed in September, 2009. It is based on a review of the most current research regarding the effects of military deployment on the children and effective interventions. Participating in the Advisory Committee that helped develop the curriculum were:

- Sadikifu Akina-James, Government Relations Officer, King County Dept. of Executive Services
- Kim Beeson, MSW, Director, Prevention Center, Puget Sound Educational Service District (PSESD)
- Diana Frey, PhD, Brainchild NW, Consultant to Washington State Dept. of Veterans Affairs (WDVA)
- Michele Haymond, CPP, Coordinator, Safe and Drug Free Schools and Communities, PSESD
- Francisco Ivarra, Board Member, Veterans Citizen Levy Oversight Board, King Co. Comm. Serv. Div. (CSD)
- Mona Johnson, MA, CCP, CDP, Director, Learning and Teaching Support, Operation Military Kids, Office of Superintendent of Public Instruction
- Larry Knauss, PhD, Chief of Program Evaluation, AMEDD's Child, Adolescent and Family Behavioral Health Proponency
- Andrea N. LaFazia-Geraghty, MSW, MPH, Project Manager, Mental Illness and Drug Dependency Plan, King County Mental Health, Chemical Abuse and Dependency Services Division
- Pat Lemus, Deputy Director, King County CSD
- Tom Schumacher, MS, LMHC, NCC, CTS, Director, PTSD/War Trauma Outpatient Program, WDVA

The program selected Nelson Middle School in Renton to pilot the curriculum during the 2009/2010 school year. Two guidance counselors at Nelson were trained in the curriculum and begin using the curriculum in the spring of 2009. Following the successful pilot, Kent, Auburn and Federal Way school districts were chosen to implement the curriculum during the 2010/2011 school year. Through 2010, a total of 32 children of military families have participated in the curriculum.

MOST RECENTLY MEASURED OUTCOMES

The curriculum has been developed, tested and is now being implemented in three school districts for the 2010/2011 school year. Outcome results are not yet available but are expected in 2011.

Client Story

There are no client stories at this time.

Evaluation Questions

How was the program expanded with Levy funding?

Until this program initiated, there was no similar program in King County. In 2009 the curriculum was developed based on the best available research and under the guidance of educational and therapeutic experts. The curriculum contains eight specific units that address the following:

- Recognition and validation of student concerns and engaging students in discussions
- Deployment and re-deployment
- was Homecoming, reunion and post-deployment
- Coping with stresses specific to military-impacted students
- Understanding impacts of grief, loss, and death
- Development of a skill set to foster resiliency
- Self-care and coping skills
- Closure activity and plans for support when needed

In 2009, the curriculum was piloted in the Renton School District. The curriculum and training tools were adjusted based on the pilot test results. The revised curriculum was implemented in the Kent, Auburn and Federal Way school districts for the 2010/2011 school year.

Who has been served through this program?

Through 2010, the program served 32 children of military families in the Kent, Auburn, and Federal Way school districts.

How effective have services been?

Outcome information on the curriculum is not expected until 2011. However, the curriculum was well researched and is based on best practice and evidence-based strategies. If the program is implemented with fidelity, a relatively high rate of positive outcomes can be expected.

There are preliminary indications that identifying and enrolling youth into the programs is difficult. It appears youth may not want to be identified with the program despite incentives. If low enrollments continue, this will reduce the program's impact.

Are any changes in the program model anticipated?

Because of the difficulties engaging youth in the program, new avenues for identifying and enrolling youth are being explored. If any are found to be effective, they will be considered for implementation.

Lesson Learned

1. Curriculum copies should be available for facilitator training.
2. Training time must be expanded to cover curriculum content. The content is useful, rich, detailed, thoughtful, but highly time consuming. There is more content than the counselors can reasonably expect to cover in the time originally allotted.
3. Strategies for engaging youth in the program are essential to its success.

STRATEGY 1, Activity 1.1.C
Outreach to Special Populations

Purpose / Objective: 1.1.C Increase access to veteran's benefits and services for populations that are traditionally under served

Activity 1.1.C Develop an outreach program for under-served veteran communities of color and women veterans to help ensure that they are linked to veteran's benefits, services and other resources in a culturally appropriate manner.

Services Start Date: September 2010

Agencies funded: Community Psychiatric Clinic, Therapeutic Health Services and El Centro de la Raza

Performance Measures

1. 106 persons contacted and served
2. 65 persons applying for and/or receiving benefits and services after referral by outreach agencies
3. 25 clients who had previously not accessed or were disconnected from veterans benefits/services were reconnected with veterans benefits and services
4. 45 percent of the clients reported satisfaction with outreach services provided

SERVICES PROVIDED - 2010

Three agencies were selected to implement this program through an RFP conducted in 2010. Each agency had a different focus: El Centro de la Raza on Latino veterans, Therapeutic Health Services on African American veterans and the Community Psychiatric Clinic on the most at-risk and most in need women veterans and veterans of color. These agencies began work in September to identify and engage their target populations; link them to veterans' benefits, services and resources; and refer them to other regional housing, health and human services. Services provided include outreach, advocacy, resources and referrals to the VA, the King County Veterans Program and mainstream services for qualifying women and minority veterans needing to be re-connected to services. Through 2010, 106 veterans and family members had been served.

MOST RECENTLY MEASURED OUTCOMES

The number of clients reporting satisfaction with outreach services provided.

- Sixty-five clients of the 106 clients served (61%) were successfully linked to additional services and benefits.
- Forty-eight of the clients served (45%) reported satisfaction with the services received.

Client Story

The client was a Vietnam Era veteran of color who has been suffering from mental health and chemical dependency issues since his return from war. He had been involved with the criminal justice system and was homeless. In addition, he had recently begun to suffer from dementia. He had never received VA benefits although he had been eligible for over 30 years. The outreach team helped him enroll in the King County Veterans Program and secure his VA benefits. The outreach team and KCVP worked together to make sure he was going to all of his medical appointments and orientations and he was able to secure housing through the Veterans Affairs Supportive Housing (VASH), which is the VA's housing program.

Evaluation Questions

How was the program expanded or enhanced with Levy funding?

This is a new program developed with VHS Levy funding. Three agencies were selected to conduct this work through an RFP process--the Community Psychiatric Clinic outreaching to at risk women veterans and veterans of color, Therapeutic Health Services outreaching to African American veterans and El Centro de la Raza outreaching to Latino veterans. These agencies began work in September to identify and engage minority and women veterans and family members; link them to veterans' benefits, services and resources; and refer them to other regional housing, health and human services.

Who has been served through this program?

Out of the 106 women veterans, veterans of color, and their family members that have been served by this program, El Centro de la Raza served 21, Therapeutic Health Services served 30, and 55 were served at the Community Psychiatric Clinic.

Eighty-nine percent of the clients served were people of color. Of those 60 percent were African-American, 10 percent Latino, 6 percent Native American, 4 percent Pacific Islander, 1 percent Asian, 5 percent multi-racial and 3 percent "other". Just over one third of the clients were female. Seventy percent of the clients lived in single person households and only 14 percent had children. Ninety-one percent of the households had very low or low incomes. Nearly one-third were homeless. The program manager at El Centro de la Raza reported that, in comparison to veterans served elsewhere, fewer of the veterans served were VA connected and they generally were unaware of the benefits for which they were eligible.

How much service has been provided?

During the start-up phase, the outreach teams developed all of the intake forms and the outreach systems to be used. Strong relationships were established with referral agencies and program staff familiarized themselves with the many and diverse Veterans Affairs offices and resources at the state and federal levels. They also initiated outreach activities focusing on the target audience. Since the teams began operations, 106 veterans and family members have been served.

How effective have services been?

Sixty-five clients (61%) were successful linked to a variety of health care services and veterans benefits. These linkages have allowed veterans to pay rent and stabilize their living situations and improve their overall well being. Forty-five percent of the clients served reported that they were satisfied with the services received.

The agencies' program managers report that the program has been successful in providing the necessary information to the target communities in King County through personal contact as well as utilizing media and mass communication tools.

Are any changes in the program model anticipated?

Initially El Centro de la Raza was only targeting Latino veterans thru outreach activities and thru collaboration within the social services programs at El Centro. That agency has now expanded the services to accommodate all minorities and women veterans of King County and have also improved its outreach techniques, utilizing more the personal approach as well as the use of community organizations to reach participants.

Lesson Learned

The use of mass media and targeted outreach strategies are successful outreach methods. If these methods had been implemented initially, the program would have had earlier success.

STRATEGY 1, Activity 1.1.D

National Guard Family Assistance Family Coordinator

Purpose / Objective: 1.1.D Reduce the impact of service on the members and families of National Guard and Reserves

Activity 1.1.D Establish a new program to provide outreach services to King County National Guard and Reserve members, veterans and their family members

Services Start Date: September 2009

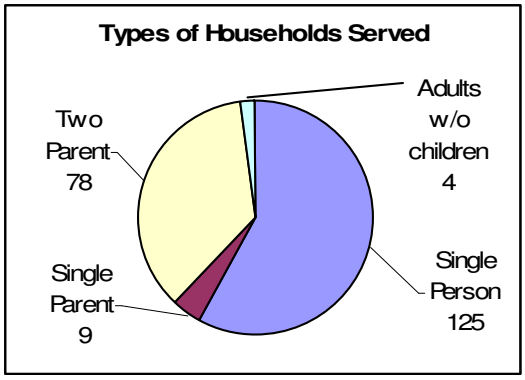
Agencies funded: Washington State Department of Veterans Affairs (WDVA)

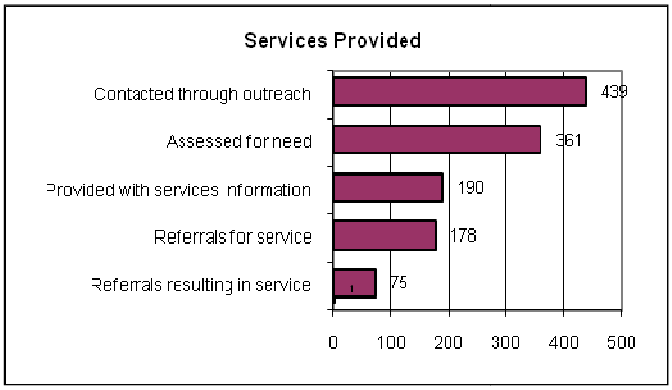
Performance: September 1, 2009 – December 31, 2010

1. 439 clients contacted through outreach
2. 361 households assessed
3. 178 referrals made to support services
4. 95 of 127 clients (75%) demonstrated increased stability within six months of initial assessment

SERVICES PROVIDED

During its sixteen months of operation, 357 National Guard and Reserves households and 439 individuals were contacted by the program. The Military Family Outreach Specialists assessed 361 individuals for need and provided 190 individuals with service information. One hundred seventy eight service referrals were made.





MOST RECENTLY MEASURED OUTCOMES

The number of clients demonstrating increased stability within six months of initial assessment.

- Ninety-five of the 127 clients (75%) assessed on the outcome showed increased stability within six months of receiving benefits or services.

Client Story

Todd was a National Guard member who had just finished two tours in Iraq as a sniper. He had been trying to find work with little success. He was also experiencing some PTSD. He met with the program's outreach specialist to discuss his employment plans and educational options. The specialist advised Todd on some employment leads and recommended use of the GI Bill to return to school. Todd is now working full-time with a local construction company. He has begun PTSD treatment and is saving so that he can move into his own place.

Evaluation Questions

How was the program expanded or enhanced with Levy funding?

Services started September 1, 2009 for recently returned National Guard members. One Military Outreach Specialist was hired and assigned the initial task of contacting each member of the 81st Brigade Combat Team residing in King County that filed a VA claim. The Military Outreach Specialist helps National Guard and Reserve members and their families with a variety of issues that arise when they are activated for military service such as loss of civilian jobs, loss of income, family stress related to military service, and changes in normal life routines due to military service. The Specialist assesses family needs providing information, assistance, referral, advocacy and follow-up services

Who has been served through this program?

While 59 percent of the households served were single adults, over 30 percent were families with children. Fifty-seven percent of the households were very low or low income. Over two-thirds of the participants lived in south King County (70%). Others lived in east King County (15%), Seattle (13%), and north King County (2%).

How effective have services been?

Ninety five of the 127 clients (75%) assessed on the outcome showed increased stability within six months of receiving benefits or services. Stability was improved in a number of ways including: gaining employment, increasing income, reducing family stress, and returning to normal life routines. Program staff attributed the positive outcomes to successful linkage of client families to needed support services. The only individual that was not linked to services through referral is a single NGWA service member.

Are any changes in the program model anticipated?

No program changes are anticipated at this time.

Lesson Learned

1. New programs need to be flexible and adaptive. When the anticipated referral pipeline to the Washington National Guard did not materialize, program management had to quickly identify and cultivate other viable referrals sources. In 2009, the program added another approach – mailing program contact information directly to discharged veterans.
2. Prompt engagement is important to success. Most participants were very grateful for the quick responses to their assistance request, although some were hesitant to provide personal financial information. Once families engaged in the needs assessment process, the program's benefits became clearer to them.

STRATEGY 1, Activity 1.2.A.1

Increase Capacity of KCVP Financial Services

Purpose / Objective: 1.2.A Reduce the impact of immediate financial strain on household stability by providing funds to meet basic needs and overcome financial crisis

Activity 1.2.A.1 Increase the amount of short-term financial assistance available to low-income veterans, active military and their families so that they can resolve immediate financial crises and achieve economically stability.

Services Start Date: November 2006

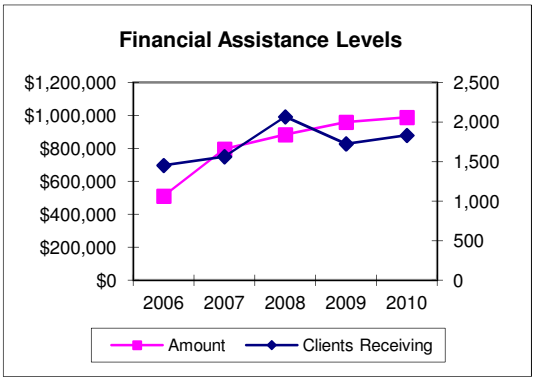
Agencies funded: King County Veterans' Program (KCVP)

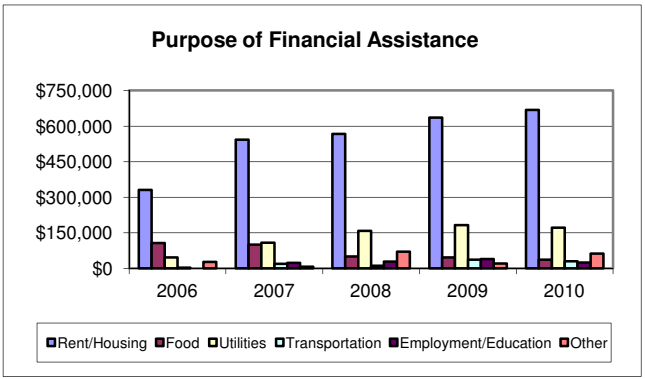
Performance: November 2006 to December 2010

1. 8,648 clients receiving financial assistance since levy funding began
2. $2,184,467 of financial assistance with levy funds
3. 71% of clients receiving financial assistance for housing purposes retained their housing for six months.

SERVICES PROVIDED

The amount of financial assistance provided to KCVP clients nearly doubled from 2006 ($511,164) to 2009 ($989,529) with the infusion of levy funds. Over that span, 8,648 clients received a total of $4,142,074 in financial assistance--$2,184,467 from levy funds. Two-thirds of the assistance was for housing—either rent or mortgage assistance. Other common purposes were utility payments and food.





MOST RECENTLY MEASURED OUTCOMES

Eighty-seven percent of KCVP's clients provided financial assistance through vouchers improved their self-sufficiency. For three quarters of the clients this was through enduring income increases. Sixty-five percent stabilized their housing situations and 56 percent stabilized their employment. Seventy-one percent of the clients provided financial assistance specifically for mortgage or rental assistance was able to retain their housing for six months or longer.

Client Story

William (not his real name) wanted to move into an apartment but lacked the financial resources to pay the first and last months' rent. KCVP provided rental assistance and connected William to the federal Home Affordable Modification Program for more loan support. William was able to move into a new apartment three months later.

Evaluation Questions

How was the program expanded or enhanced with Levy funding?

The amount of financial assistance provided to KCVP clients nearly doubled from 2006 ($511,164) to 2009 ($989,529) with the infusion of levy funds s. A total of $4,142,074 has been provided in financial assistance since 2006. Of that, $2,184,467 was levy funded. Levy financial assistance grew from $150,000 in 2006 to $605,833 in 2010.

Who has been served through this program?

Between 2006 when levy funding became available and 2010, 8,648 clients received financial assistance. Sixty-three percent of all KCVP clients received financial assistance. An average of $479 was provided to the families seeking assistance. Sixty-six percent of the funds were used for housing assistance—rent or mortgage payments. Sixteen percent of the funds were used for utility payments and 7 percent to purchase food. Other assistance was for employment/educational expenses, medical expenses, and transportation costs.

How effective have services been?

It is difficult to isolate the effects of financial assistance from the other support services provided by KCVP. The financial assistance provided almost always helped to resolve the immediate crisis. For instance, 71 percent of those provided financial assistance for rental or mortgage payments successfully retained their housing for six months or longer. Others avoided utility shut offs with the financial assistance provided.

Are any changes in the program model anticipated?

No. The intention is to maintain focus on financial assistance that leads to sustained self-sufficiency. Some adjustments may be needed in late 2011 in response to the Levy renewal efforts.

Lesson Learned

1. Financial assistance based on thorough client assessment and intended to increase self-sufficiency is more effective than an entitlement program that fosters dependence.
2. Up-to-date financial reporting is essential to managing financial assistance across multiple funding sources.
3. Fund assignment polices are necessary when multiple fund sources are used. These policies ensure that funds are assigned and used appropriately.

STRATEGY 1, Activity 1.2.A.2

Increase Capacity of KCVP for Additional Shelter Beds

Purpose / Objective: Reduce the impact of homelessness by providing emergency shelter and transitional housing to veterans through vouchers to service providers

Activity 1.2.A.2 Provide homeless veterans a safe place to be and a means to transition to more permanent housing

Services Start Date: December 2007

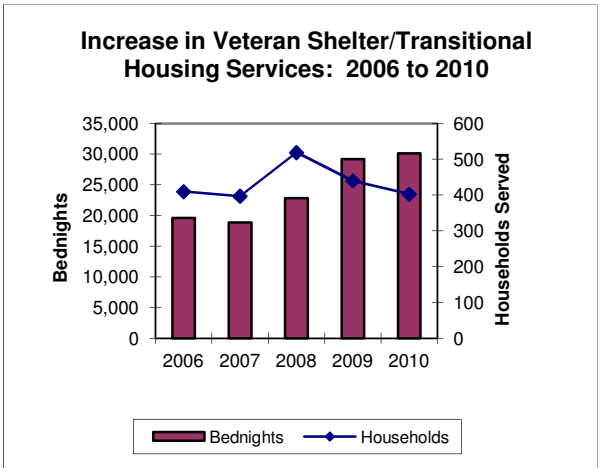
Agencies funded:
The Compass Center
The Salvation Army - William Booth Center

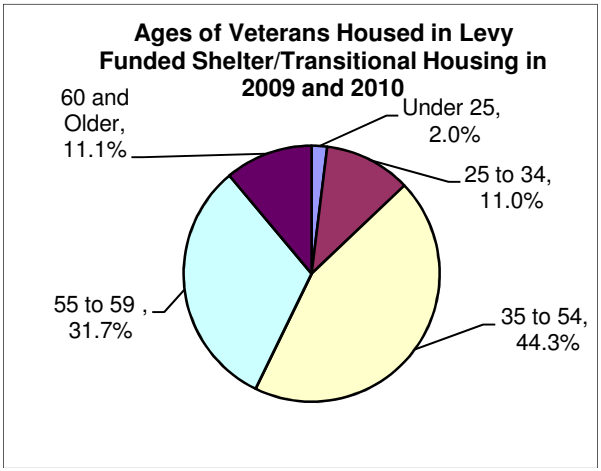
Performance Measures

1. 1,114 persons sheltered
2. 41,647 nights of emergency shelter
3. 10,132 nights of transitional housing

SERVICES PROVIDED

Levy funding has been used to contract for more transitional housing for homeless veterans. Approximately half of all shelter and transitional housing provided by KCVP since 2008 is Levy-funded. Housing allows KCVP staff to stabilize clients so that long-term self-sufficiency plans can be created and started. The overall veterans' shelter and transitional housing system has seen steady service increases as levy funding has entered into the system.





MOST RECENTLY MEASURED OUTCOMES

The primary outcome for the emergency shelter and transitional housing programs is moving clients to more stable housing situations—from emergency shelter to transitional housing or transitional housing to permanent housing. Of the 267 households measured on this outcome since 2006, 176 (65.9%) transitioned to more stable housing.

Client Story

Brad was a Gulf War veteran looking for a job and a place to stay. The KCVP staff was able to secure him transitional housing at the William Booth Center (WBC). The program also provided vouchers for clothing and bedding. During

his stay at WBC, Brad was able to find a job. He eventually moved to his own apartment with financial assistance from KCVP.

Evaluation Questions

How was the program expanded or enhanced with Levy funding?

KCVP used levy funds to purchase additional transitional housing bed nights at the Compass Housing Alliance's Pioneer Square Men's Program and the Salvation Army's William Booth Center. KCVP added levy funding to these agencies' contracts beginning December 1, 2007. The Pioneer Square Men's Program was contracted to provide 8,768 transitional housing bed nights for veterans through 2010. The William Booth Center, which was already under contract, increased its bed night target by another 23,060 bed nights through 2010.

Who has been served through this program?

Single men are served in the shelter-transitional housing programs. All those served in 2009 and 2010 were homeless single men. Most of those served were older—only 13 percent were under 35. Nearly a third (32.8%) were 55 or older. Most veterans provided shelter were either white (51.4%) or African-American (39.6%). Thirteen percent stated they were Hispanic. Fifty-five percent of the sheltered veterans claimed Seattle as their last permanent address. Another 18 percent were coming from outside King County for housing assistance.

How effective have services been?

The transitional housing services were very effective. Sixty-six percent of the veterans served in these programs moved on to more stable housing—many into permanent housing. The permanent housing was usually either rental housing or permanent supportive housing where veterans would receive the support services necessary to maintain their housing stability.

Are any changes in the program model anticipated?

No. The strengthened linkages with permanent supportive housing programs are increasing the successful exit of transitional housing clients. The task is maintaining these linkages in the future.

Lesson Learned

1. It is critical to have good communication and follow-up between the shelter and support service programs if clients are to be successful.

2. Transitional housing does provide veterans a safe place to be and keeps them off the streets.

3. Transitional housing is effective when linked to permanent housing. Veterans leaving transitional housing need permanent housing that offers the support services necessary to sustain them.

STRATEGY 1, Activity 1.2.A.3

Increase Capacity and Number of Housing Units for Veterans

Purpose / Objective: Reduce the number of veterans who are homeless by increasing the number of permanent housing units available to serve them

Activity 1.2.A.3 Create a Veterans Housing Planner position to assess different housing options and provide an effective housing inventory tool for housing providers. The planner provides technical assistance to veterans' agencies, and housing and service providers, as well as providing clients with housing-related supportive services.

Services Start Date: August 2009

Agencies funded: King County Community Services Division

Performance: August 1, 2009 – December 31, 2010

1. A veterans' housing assessment has been completed
2. A veterans' housing assessment tool is in place and being used to track veterans' housing units.

SERVICES PROVIDED – 2009 and 2010

The Veterans Housing Planner was hired in August, 2009. The planner met with 22 organizations involved with shelter, transitional housing and permanent housing regarding homeless veterans' needs and the ability of the shelter-housing system to meet those needs. Those agencies are:

- Compass Center (now Compass Housing Alliance)
- Catholic Housing Services
- Evergreen Treatment Services – Project Reach
- Downtown Emergency Services Center
- Low Income Housing Institute
- Sound Mental Health
- Plymouth Housing Group
- Veterans Administration – Homeless Vet. Services
- Washington State Department of Veterans Affairs
- King County Veterans Program
- The Salvation Army – William Booth Center
- Community Psychiatric Center
- YWCA – Liaison Program/HASP
- Santos Place
- Healthcare for the Homeless
- NAVOS
- Pack Parachute
- Valley Cities Counseling and Consultation
- King County Community Health Services Division
- King County Criminal Justice Initiatives Project

The planner subsequently completed a comprehensive Veterans Housing assessment, including inventory of veterans' shelter and housing. The planner represent King County in committees/groups such as the Seattle-King County Veterans Consortium and SHAVETS (Supportive Housing Alliance for Veterans) and has assumed a significant staffing role in the Five-Year Plan to End Veterans Homelessness—an initiative from the Funders' Group of the Committee to End Homelessness (Ten Year Plan). This body of work will be completed by April 2011.

MOST RECENTLY MEASURED OUTCOMES

The products expected from this activity have been created—a comprehensive veterans housing assessment and an assessment tool that can continue to be used. More importantly, since the Veterans Housing Planner began this activity, 105 VASH vouchers (for 2010), 52 permanent supportive housing units, and about 77 HASP section 8 housing vouchers have been set aside for veterans .The Compass Veterans Center in Renton was opened with 22 VASH vouchers, 15 for singles and 7 for families, as well as 38 Grant and Per Diem units. While these new units are due to many factors, having a housing planner actively representing veterans' interests has no doubt helped.

Client Story

No client story at this time.

Evaluation Questions

How was the program expanded or enhanced with Levy funding?

This position did not exist prior to Levy funding. Its purpose is to examine the current veterans' shelter and housing services system and identify potential improvements. The first objective was to produce a report describing homeless veterans' needs in King County, inventorying the shelter and housing available to homeless veterans and offering recommendations for adjusting the veterans' shelter system. This was completed in 2009.

Following these activities, the VHP has been involved in the Five-Year Planning process to End Veterans Homelessness in King County. This work includes staffing the Advisory Committee—made up of housing, service, and veterans organizations.

Who has been served through this program?

The Veterans Housing Planner has contacted 22 agencies regarding veterans' shelter and housing services in King County. She has met with shelter-housing providers, support service providers, advocacy groups, and veteran serving organizations. She has also participated in regular meetings with veterans support organizations such as the Seattle-King County Veterans Consortium and the Supportive Housing Alliance for Veterans (SHAVETS) group.

How effective have services been?

The Veterans Housing Planner has been effective in elevating the issue of veterans' shelter-housing access and engaging stakeholders in considering improvements. Since she began this activity, 105 VASH vouchers (for 2010), 52 permanent supportive housing units, and about 77 HASP section 8 housing vouchers have been set aside for veterans. While these new units are due to many factors, having a housing planner actively representing veterans' interests has no doubt helped

Are any changes in the program model anticipated?

The Veterans Housing Planner position is slated to expire by April 2011. The ending of this position leaves a gap for implementation of the Five-Year Plan to End Veterans Homelessness. Other resources will be needed to update the veterans housing inventory, present findings to veterans' groups/community on veterans' housing/services needs, and to attend to specific veterans housing issues as they emerge.

Lesson Learned

1. Planning early has advantages. Because King County had a veterans housing planner in place, she was able to contribute to and have the opportunity to affect federal policy.
2. Having someone specifically look through a "veterans and housing issues lens" is very helpful, especially given the current climate which has heightened the support for veterans as they return from Iraq and Afghanistan. It has helped make King County more visible at the federal level.
3. Planners need to proactively communicate and collaborate with stakeholders. There are many committed stakeholders that can be effective allies when fully involved in the process.

STRATEGY 1, Activity 1.2.B

Contracted Post Traumatic Stress Disorder Treatment for Veterans and Their Families

Purpose / Objective: Reduce the symptoms and impacts of PTSD on the lives of veterans and their families

Activity 1.2.B Expand the number and service sites for Post Traumatic Stress Disorder treatment services for veterans throughout King County

Agencies funded: Washington State Department of Veterans Affairs (WDVA)

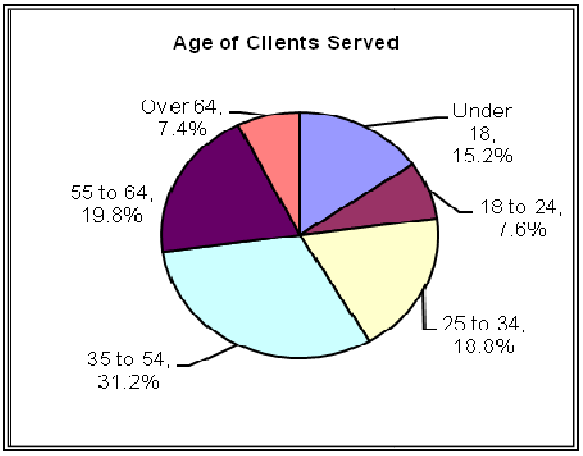
Performance: April 1, 2007 – December 31, 2010

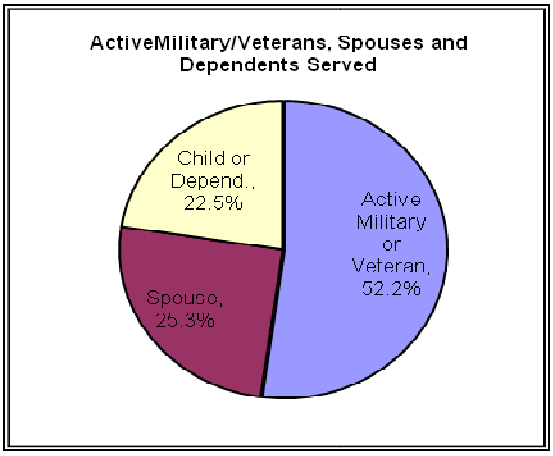
1. 644 clients received levy funded PTSD treatment
2. 9,536 hours of PTSD counseling
3. 4,765 hours of community education and professional training on PTSD
4. Ninety seven (97%) percent of the 615 clients assessed in since 2006 demonstrated reduced impacts of PTSD

Services Start Date: April 2007

SERVICES PROVIDED

The Washington State Department of Veterans Affairs (WDVA) contracts with qualified counselors throughout King County to provide Post Traumatic Stress Disorder (PTSD) counseling and treatment for Veterans and their dependents assessed for and found to have PTSD.





MOST RECENTLY MEASURED OUTCOMES

Ninety-seven (97%) percent of the 615 clients assessed since 2006 demonstrated reduced impacts of PTSD as measured on a battery of mental health and psychological tests. This level of success has been consistently maintained throughout Levy implementation.

Client Story

Fred (not his real name) is a 29-year-old Army veteran who had served two tours in Afghanistan and one in Iraq. Upon his return to civilian life, Fred began to have a number of emotional and concentration problems. He could not sleep, had nightmares, and anger was threatening to damage his marriage. At one point, he was suicidal and had to be hospitalized at the U.S. Department of Veterans Affairs Medical Center in Seattle. The VA referred him to a King County PTSD Program provider near his home. Thanks to PTSD Program intervention, Fred was able to focus upon

his continued healing and his relationships with family and employment. He has since been promoted within the transportation industry. He told the PTSD program manager that because the counseling site was more informal, closer to their residence, and available to his wife, that the services actually "saved my life and my marriage."

Evaluation Questions

How was the program expanded or enhanced with Levy funding?

Program expansion was initiated in November 2006. The Director of the PTSD/War Trauma Outpatient Program began seeking qualified PTSD counselors to offer PTSD counseling services in more King County communities. The number of providers increased from eight to 17. Additional sites throughout King County were added, especially in rural areas and in the most veteran populated areas in South King County.

Who has been served through this program?

Through 2010, 644 veterans and family members received Levy funded PTSD treatment services through Veterans and Human Services Levy funded contractors. Twenty-five percent of those served were veterans' spouses and 23 percent were children or other dependents. Nearly a third of the clients were between 35 and 54 years of age, 26 percent were 55 and older, and 15 percent were under 18 years of age. Fifty-nine percent were very low income.

How effective have services been?

The program has been very effective at creating important alternatives for veterans. Family members benefit from services that do not exist in the VA system, allowing care to be much more effective as spouses, children, and even parents or grandparents are helped to handle the needs of family members deploying or returning from war.

Since 2006, the PTSD program has had a 97 percent success rate in reducing PTSD symptoms for all clients—Revised Code of Washington j(RCW) and Levy supported. Clients are tested on a battery of mental health and psychological tests to assess their progress. The 2010 success rate of 97 percent remains high and is at the historical standard.

Are any changes in the program model anticipated?

There are barriers to care that need to be addressed, particularly in the African American community and Hispanic community; also, the program director is negotiating with the U.S. Department of Veterans Affairs to place a clinical provider directly in the VA Medical Center, Deployment Health Clinic. This would increase access to PTSD services for VA clients and family members not eligible by VA standards. The Department of Veterans Affairs is reconsidering its eligibility policy for PTSD treatment, but until this occurs there is a need for other PTSD treatment within the VA environment.

Lesson Learned

1. PTSD treatment is effective and essential to enabling traumatized veterans to regain control of their lives.
2. Academic institutions need assistance in dealing with returning veterans suffering from PTSD. The program is now working with community colleges and universities to offer training events and other support.
3. Younger veterans and active military do not immediately access PTSD services upon their return from combat. It usually takes them some time to identify the problem and to admit that help is needed. When they do, services will need to be evenly distributed throughout King County as demographic studies show them to be more equally dispersed.
4. The increased community and professional PTSD training has increased the strength of this program component. Main stream providers and others are now more aware of PTSD and the availability of PTSD treatment services.
5. Embedding a clinician within the VA Health Deployment Clinic has improved service access for those populations that the VA is not permitted to serve, e.g. families of veterans.

STRATEGY 1, Activity 1.2.C

Contracted Veterans Incarcerated Program

Purpose / Objective: Assist incarcerated veterans to overcome factors contributing to jail use and promote long term health and stability upon release

Activity 1.2.C Increase the capacity of the WDVA's Veterans Incarcerated Program so that more veterans in municipal jails throughout the county could be served

Services Start Date: April 2007

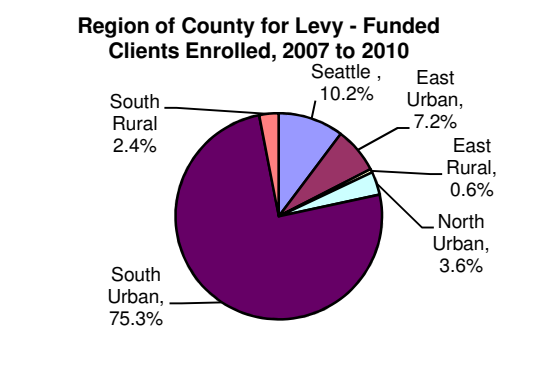
Agencies funded: Washington State Department of Veterans Affairs (WDVA)

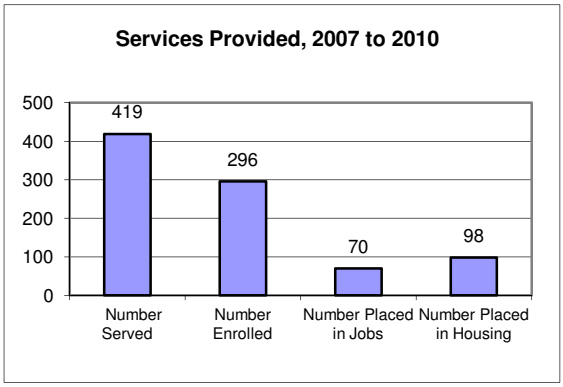
Performance: April 1, 2007 through December 31, 2010

1. 419 veterans screened and 296 enrolled in the program since 2007
2. 27,570 reduced jail days for veterans (combination of levy and other funds)
3. 579 of 647 (89.5%) achieving early release did not recidivate within the year
4. 647 veterans achieved early release over the four years of levy funding.

SERVICES PROVIDED

The Veterans Incarcerated Program is a project that reduces Veterans use of King County and suburban jails by advocating on behalf of veterans as well as providing support services to overcome circumstances that may lead to misdemeanor activities – such as unemployment, homelessness, and/or substance abuse. The project is run by the Washington State Department of Veterans Affairs (WDVA and provides intake, assessments, advocacy and case management to veterans in jail.





MOST RECENTLY MEASURED OUTCOMES

There are three related outcomes for this project: 1) the number of veterans achieving early jail release, 2) the jail days saved due to veterans' early release, and 3) the number of released veterans that do not recidivate.

- Six hundred forty seven (647) veterans achieved early release over the four years of levy funding.
- With levy funds, the early release days saved rose slightly from 5,942 in 2007 to 6,021 in 2008 but then fell back to 4,024 in 2009 and 5,616 in 2010 due to short staffing.
- Over four years of levy funding, 579 of 647 (89.5%) achieving early release did not recidivate within the year.

Client Story

Mr. Y served as an Army Ranger in Afghanistan in 2006 where he suffered a 100 percent service connected disability after his vehicle was blown up by an improvised explosive device (IED). He was on several medications and unable to work when he was arrested during an altercation with his wife. While incarcerated, he was not able to receive required medications, thereby worsening his condition. VIP staff helped connect the VA Pharmacy to the jail medical staff, met with the Vet's assigned counsel, then stood up with the Vet at his arraignment. Consequently, the charges were dropped, with over 345 saved jail days, along with the profound thanks of the Veteran and his 60 year old mother who was also his caretaker.

Evaluation Questions

How was the program expanded or enhanced with Levy funding?

The program received Levy funding beginning in April 2007. This allowed the program, which had been operating only in King County's two jails, to expand into city jails for Renton, Issaquah, Kirkland, Auburn, Kent and Enumclaw. Movement to city jails also required that the program establish connections to support services over a broader geographical area.

There was a downturn in program activity in early 2009 when one of the two staff left and the position was left unfilled through April 2009. The staffing issues continued in 2010 due to maternity leave and team management transition. Jail coverage staff was brought in from Pierce County to help until mid-2010 when full permanent staffing was established.

Who has been served through this program?

This program serves a high percentage of homeless veterans (81% since 2007). The bulk of clients served through levy funding live in south King County (78%). This is in contrast to the RCW funded portion of the program which serves predominantly Seattle clients (83% in 2010).

How effective have services been?

The program met its objective of expanding services to municipal jails. However, the jail days saved due to veterans' early release has decreased since levy funding began. About 6,000 jail days were saved in both 2007 and 2008 but that decreased to 4,024 in 2009 and 5,616 in 2010. Under-staffing and administrative turnover are the primary underlying causes of this decrease. The program's staffing is now stabilized and jail days saved was trending upward by the end of 2010. The decreased King County jail population may also be contributing to the decreased numbers served and consequently the decreased jail days saved. In addition, female inmates are not being asked their veteran status, which means some potential clients are not being identified.

The recidivism rate for program clients remains consistently well below that of other jail inmates. Program clients had a 10 percent recidivism rate over the past four years compared to 37 percent for other inmates. In 2010, the program's recidivism rate was particularly low at 98 percent.

With levy funds, the program has enrolled 296 veterans over the past four years, placed 70 in jobs and found housing for 98.

Are any changes in the program model anticipated?

The program staff is beginning to work closely with the South Correctional Entitiy (SCORE) program as it comes online in South King County. SCORE' s objective is to provide long-term jail capacity for south county cities as King County jail access decreases. SCORE is expected to have an impact on the King County misdemeanor jail population, as a whole, once SCORE goes operational in late 2011. Regular contacts and referrals to mental health programs with housing, such as FISH and THRIVE for high utilizers with Axis 1 disorders.

Lessons Learned

1. Staff members working in the jails need considerable support. The job is extremely stressful as staff members operate in constricted jail environments and deal with persons in crisis situations facing multiple obstacles. This has resulted in high staff turnover and inconsistent effectiveness. Supports, such as regular opportunities to debrief and process their experiences, are necessary to sustain staff members.

2. The program's connection to community-based support services is key to linking veterans to those services and, thereby, securing their release. When the program expanded to other jails, it was first necessary to establish connections to local support services.
3. More support services are needed for older veterans in jail. Many of the recently implemented services are not necessarily useful for this population. Most of the employment resources are aimed at the younger, current conflict veteran, as are the housing funding streams.

STRATEGY 1, Activity 1.2.D.1

Case Management, Employment, and Outreach in South and East King County

Purpose / Objective: Improve the long term financial stability of veterans and their families by providing access to livable wage jobs

Activity 1.2.D.1 Enhance King County Veterans Program's services in three ways: 1) open a service site in Renton 2) add five FTE case managers—three in Renton and two in Seattle and 3) initiate outreach and educational efforts throughout King County to alert communities to the expanded KCVP services

Services Start Date: September 2007

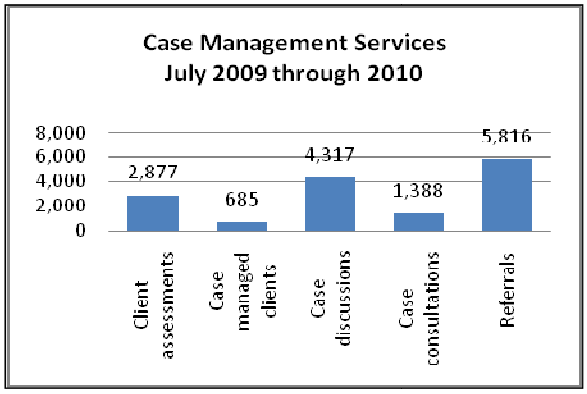
Agencies funded: King County Veterans Program

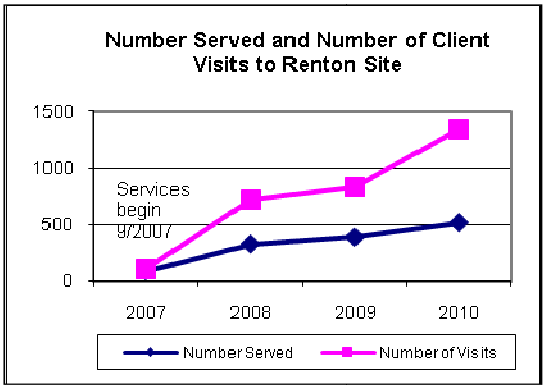
Performance Measures

1. 1,347 clients served at the WorkSource Renton site
2. Another 551 receiving case management in Seattle or satellite sites
3. 61 outreach presentations to over 1.200 attendees
4. 2,877 in-depth assessments and 685 clients case managed since 2009
5. 137 veterans and assisted family members secured employment – tracked since mid-2009.
6. 488 clients referred to and successfully obtaining alternative housing arrangements

SERVICES PROVIDED

One thousand three hundred forty seven persons have been served at the new South County site. Veterans and others seeking service made 3,001 visits at that site. Another 551 clients received case management services in Seattle or at one of the satellite sites. Case managers at all service sites completed 2,877 in-depth assessments through 2010 and 685 clients have been case managed since 2009. There were 62 outreach presentations on veterans' services to over 1,200 attendees.





MOST RECENTLY MEASURED OUTCOMES

- Eighty-seven percent of the case managed clients improved their self-sufficiency by stabilizing housing, securing employment or increasing their income.
- Case managed clients accomplish 76 percent of their case plan objectives.

Client Story

Ken K. is a 52-year-old white male Navy veteran. Ken came to KCVP looking for shelter. He had been homeless and unemployed over five months and had been staying in a variety of shelters, which was taking a toll on his health. Ken engaged in case management services and was placed at the William Booth Center Shelter. Ken followed through

with all referrals for housing and employments. With housing stabilized at the William Booth Center shelter, Ken was able to get a job. Once he felt secure in his new job, Ken secured an apartment of his own. KCVP has helped him with transportation and Ken has maintained his employment and housing.

Evaluation Questions

How was the program expanded or enhanced with Levy funding?

In 2007, KCVP used levy funds to open an office co-located with WorkSource Renton to serve south county residents. The co-location with WorkSource enabled ready access to employment services for veterans who needed occupational training or job placement. For twelve months from July 2008 to June 2009, the Renton social workers also staffed the Veterans Memorial Building in Auburn one day a week to broaden program outreach. In mid-2009, the Auburn site was relocated to WorkSource Auburn and outreach in the area transferred to satellite site staff.

Five new case managers were hired in late 2007 to provide enhanced case management services to clients and families facing multiple barriers to sustained stability. Three new social workers were hired for the Renton office and two for the Seattle office to conduct thorough assessments, provide on-going support and to facilitate service linkages to these clients.

Outreach to all areas of King County was strengthened by assigning one KCVP administrator in June 2009 to conduct educational presentations and outreach to community groups in all areas of King County. Sixty-two community meetings were conducted in all areas of King County to over 1,200 attendees.

Who has been served through this program?

All persons served at KCVP's Renton site are part of this program as well as clients at other service sites who receiving case management services. One thousand three hundred twenty seven persons have been served at the Renton and Auburn Veterans Memorial Building sites. The volume of clients has grown steadily from 112 in 2007 to 520 in 2010. Renton and Auburn clients differ from KCVP clients served in Seattle. In comparing Renton/Auburn clients to Seattle clients served since the Renton office opened, they are more likely to be female (10.6%) compared to Seattle clients (6.7%). They are much more likely to be married or divorced (34.7% compared to 9.8%). They are less likely to identify as having a handicap (31% compared to 44.4%). Not surprisingly, many more clients are from south King County (72.7%) than for those served in Seattle (25.5%).

Since case management services were enhanced in late 2007, 2,800 clients received in-depth assessments. Six hundred eighty five clients have been assigned to case management since 2009, 551 of those in Seattle or at satellite sites. These are clients facing considerable challenges to achieving self-sufficiency that need more support.

How effective have services been?

Opening the Renton site the number of south King County residents receiving veterans' services has increased nearly 50 percent. It is unknown whether the co-location with WorkSource Renton facilitated access to employment services. That information is now being tracked and will be available in 2011.

Enhanced case management has been effective in moving veterans toward long-term stability. Eighty-seven percent of the case managed clients served between July 2009 and December 2010 increased their self-sufficiency during their service period. They accomplished 76 percent of their case plan objectives by stabilizing housing, obtaining employment, securing benefits or making some other advancement.

The outreach efforts were useful in identifying potential KCVP satellite sites. Anecdotally, satellite site staff report that some clients learned about the new sites from the outreach presentations.

Are any changes in the program model anticipated?

No changes are planned at this time. There may need to be some adjustments depending on the results of the Levy renewal efforts.

Lessons Learned

1. Opening a new services hub in south King County has made services more accessible to veterans and their families. People are accessing the Renton office in growing numbers as it has become more established.

2. Case management is effective for those clients to working on their problems.
3. More veterans can benefit from case management than originally thought. The scores on the new assessment tool confirm this. There isn't sufficient staffing to provide case management to all veterans who could use it.
4. It takes time and work to open a new facility. Physical space must be secured. Office procedures must be developed for a new working environment. New staff members must be trained in the program operations. Marketing the new office to potential customers and other support services also required considerable staff time.
5. Case managing troubled veterans places considerable stress on social workers. Many clients have mental health issues and are unstable. More staff support is needed to maintain staff in this environment.
6. A well functioning MIS is essential to operating at multiple sites and facilitating coordinated client services.

STRATEGY 1, Activity 1.2.D.2

Homeless Veterans Reintegration Project

Purpose / Objective: Improve the lives of vulnerable, homeless veterans by helping them attain and maintain a stable life

Activity 1.2.D.2 Help homeless sheltered veterans and military personnel transition to more stable living situations and achieve successful reintegration into the community.

Services Start Date: April 2007

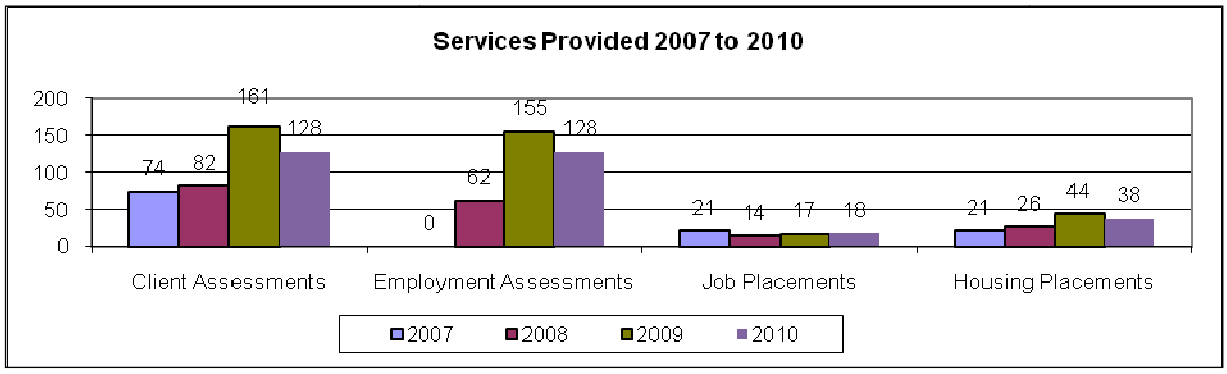
Agencies funded: Washington State Department of Veterans Affairs (WDVA)

Performance: April 1, 2007 through December 31, 2010

1. 445 clients interviewed and assessed
2. 345 clients receiving employment assessment
3. 129 clients placed in housing
4. 70 clients placed in jobs
5. 37 clients retained employment for 90 days
6. 50 clients retained housing for 60 days

SERVICES PROVIDED

The project steadily increased service levels as levy funding was added from 2007 through 2009. In 2010, service levels declined slightly. Over the life of Levy funding, the single project staff member interviewed and assessed 445 veterans. Employment assessments were conducted with 345 clients resulting in 70 job placements. One hundred twenty nine clients were placed in transitional or permanent housing.



MOST RECENTLY MEASURED OUTCOMES

There are two outcomes for this project: 1) the number of clients who retain employment for 90 days and 2) the number of clients who retain housing for 60 days.

- 55.2 percent of those placed in jobs retained the job for 90 days.
- 48.9 percent of those who were placed in housing retained that housing for 60 days.

Client Story

Victor (not his real name) came to the project after serving ten years in federal prison. After incarceration, he was assigned to work release in Seattle. That is where project staff made contact with him. He needed to get his driver's license, and clothes that would enable him to have a job–ready appearance for job interviews. The project provided those items to Victor. Shortly thereafter, he called and said he had a job offer, but needed help with certain required items to get the job. He had to have the proper work uniform, a portable GPS device, and a tri-county Thomas Guide

Map Book. Now, Victor is working for a local freight company making $14.94 an hour. He has been doing a very good job and the company is considering him for supervisor training.

Evaluation Questions

How was the program expanded or enhanced with Levy funding?

Levy funding enabled the project to serve more veterans and to offer more services. The program's outreach efforts were enhanced to serve clients in areas previously not receiving services. More training opportunities were offered in a greater variety of occupational areas. In some instances, the Homeless Veterans Reintegration Project was able to coordinate outreach efforts with the King County Veterans Programs satellite site program.

Who has been served through this program?

Four hundred forty five clients were served with levy funding between 2007 and 2010. Most of these persons received assessment and referral services only. The remaining 40 percent was accepted as case managed clients. In 2010, for instance, 56 of the 128 veterans assessed became case managed clients. For all persons served, 87 percent were homeless and 75 percent were unemployed. Ninety-two percent were male. The majority lived in south King County (55%); 26 percent lived in Seattle, 17 percent lived in east King County; and two percent in north King County.

How effective have services been?

The program was effective with the case managed clients. Of the 43 homeless case managed clients, 38 (88%) were placed in housing. Of the 24 unemployed case managed clients, 18 (75%) were placed in jobs. Those case managed clients placed in jobs retained them for at least 90 days or 67 percent of the time. Those placed in housing retained it 75 percent of the time.

It is not clear how effective services were for the approximately 60 percent of the clients who did not receive case management services. These clients have homelessness and unemployment rates similar to case managed clients. While they do receive referrals for housing, employment and other services, there is little program follow-up to determine if these clients are successfully linked to outside services.

Are any changes in the program model anticipated?

The project is developing working relationships with a broader array of support service agencies. Among these new collaborating agencies are: the Community Psychiatric Clinic, THRIVE, Help Link, and Mt. Zion Baptist Church.

Lesson Learned

1. More staff resources are needed in order to learn more about the project's effectiveness in stabilizing veterans. Locating and following up with released clients is a time consuming process.
2. Staff time is limited and the service demands of active clients are the first priority. With additional resources, future examination might reveal which veterans can best benefit from these services and which interventions would be most effective.
3. In a difficult job market, job training is a more realist objective than job placement. The project assists clients with this by placing them into training classes, so they can develop more marketable job skills. The project also helps by educating and assisting clients toward making more attainable goals in today's job market.

STRATEGY 1, Activity 1.2.D.3
Veterans Civil Legal Assistance

Purpose / Objective: Increase institutional capacity to provide civil legal assistance to at-risk or homeless veterans and their family members to reduce barriers to self-sufficiency, employment, and housing

Activity 1.2.D.3 Establish the Veterans Project at the Northwest Justice Project (NJP) to work with homeless and low income veterans to address their civil legal needs that prevent them from obtaining stable employment, income and housing; develop materials for legal advocates to work effectively with veterans; educate veteran non-legal service providers on legal referrals available; and work with volunteer attorneys and law students to increase capacity to take veteran cases.

Services Start Date: September 2010

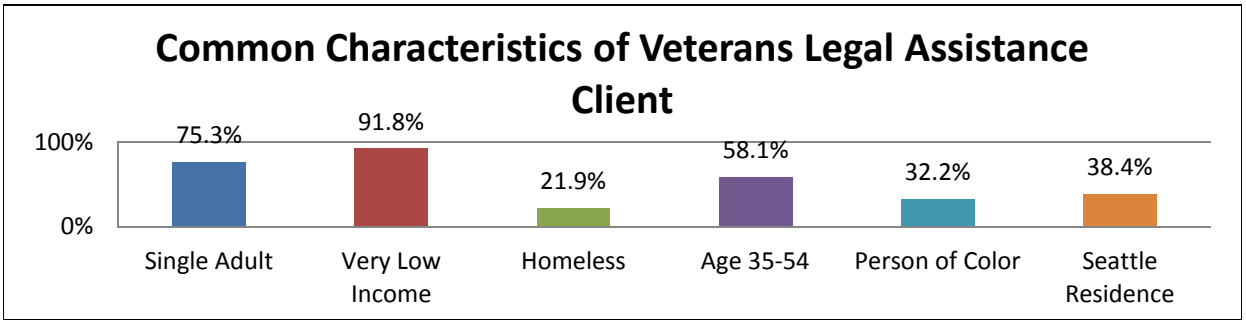
Agencies funded: Northwest Justice Project

Performance Measures

1. 74 clients assessed for level of legal assistance needed
2. 64 cases referred externally to other appropriate social services, legal aid services, pro bono attorneys
3. 22 civil legal cases successfully resolved by NJP that were a barrier to housing, employment, and self-sufficiency
4. 23.5 hours of training provided on legal issues related to veterans
5. 32 staff and other professionals receiving training on legal issues related to veterans

SERVICES PROVIDED

This program provides direct legal services to veterans and support to other attorneys representing veterans. Among the direct services are case reviews, direct client representation, and referrals for non-legal services. To support other attorneys, the program offers: attorney referrals; case consultations; attorney recruitment; training and outreach to other veteran serving organizations to develop collaborative working relationships.



In 2010, 74 case assessments/reviews were completed. Sixty-four referrals were made for social services, legal aid and pro bono attorney services. Over 23 hours of training on veterans' legal issues were given to 32 service provider staff and other professionals.

MOST RECENTLY MEASURED OUTCOMES

Twenty-two legal cases were successfully resolved through this program in 2010.

Client Story

J. K. has severe PTSD and depression resulting from his military service. Consequently, he has been on disability for years and could not obtain stable employment. When he first came to the Veterans Project, his child support payment

was almost four times Mr. K's monthly income, and the debt was growing. He wanted to help his family and daughter but the accrued debt and the large gap between his monthly payment and income was overwhelming. With the Veterans Project's help, the court agreed to Mr. K's request to modify his child support to an amount in proportion with his income. He can now pay his monthly child support, support his family, and focus his efforts on his counseling.

Evaluation Questions

How was the program expanded or enhanced with Levy funding?

Levy funding established the Veterans Project at the Northwest Justice Project (NJP). The Project is staffed by one full time attorney, and supported by law students, volunteer attorneys, and a supervising attorney. Based on veteran and service providers' identification of unmet legal needs, the Veterans Project has prioritized the follow legal areas: child support; driver's license suspensions; housing evictions and landlord-tenant issues; vacating criminal records; debt collection and other consumer law; and upgrading military discharges. The project also regularly refers the following issues to other legal advocates: family law, public benefits, and VA benefits.

Who has been served through this program?

Of the 74 King County clients served, 16 (22%) were homeless. Ninety-one percent were very low income. Three-quarters of the clients were single adults; only 16 percent lived in households with children. Fifty-eight percent of the clients were between the ages of 35 to 59; 16 percent were over 60. All clients were veterans with the exception of one who was a veteran's spouse.

How effective have services been?

Twenty-two legal cases were successfully resolved through this program in 2010. It is likely that the number of resolved case was higher than this. Outcomes for cases referred to advocates not in the project were difficult to track. Overall, the project reports great success in preventing evictions, improving housing conditions, and improving ability to pay child support by reducing payment amounts and debts. Thirteen cases are still open and five have been referred to pro bono attorneys under the project's supervision.

What adjustments were made during initial program implementation? Are any further changes in the program anticipated?

After doing an informal needs assessment of the legal areas veterans wanted assistance with, the program narrowed the scope of cases accepted to areas that no one else works on but are a high need for low-income and homeless veterans. Intensive outreach to veteran organizations caused a huge flow of cases to the program. Since the program consists of only one attorney, the need rapidly exceeded program capacity. The program is now working on increasing its capacity by recruiting pro bono attorneys to take cases, hiring a volunteer law student for the school year, and hiring two full time law students for the summer.

Lesson Learned

1. Working with law students who are veterans themselves provides them good professional experience, but also encourages their interest in public service and in working with veterans in their future careers.
2. Ongoing adjustments on case flow will be necessary for this program's success.
3. One of the most important goals for this program is to increase capacity among other advocates to provide more effective legal services when they are working with veterans. To that end, a second year of the fellowship would provide the time and experience needed to develop toolkits for other attorneys and advocates and give trainings on legal issues that greatly affect veterans.
4. There is a huge need for legal services for this population. This program really provides the only legal aid focused entirely on veterans in Washington State. Veteran clients, social workers and other service providers, greatly benefit from this program's assistance.

STRATEGY 1, Activity 1.2.E

Veterans Conservation Corps Program

Purpose / Objective: Improve the long term financial stability of veterans and their families by providing access to livable wage green jobs

Activity 1.2.E Provide job placement, employer training, and individual training services in environmental restoration and stewardship for eligible veterans and other military personnel.

Services Start Date: August 2008

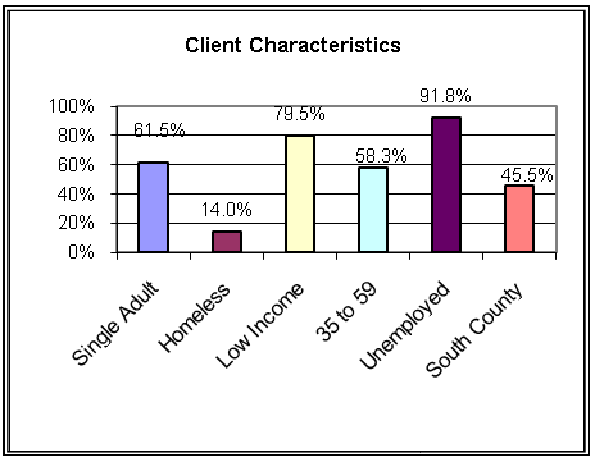
Agencies funded: Washington State Department of Veterans Affairs (WDVA)

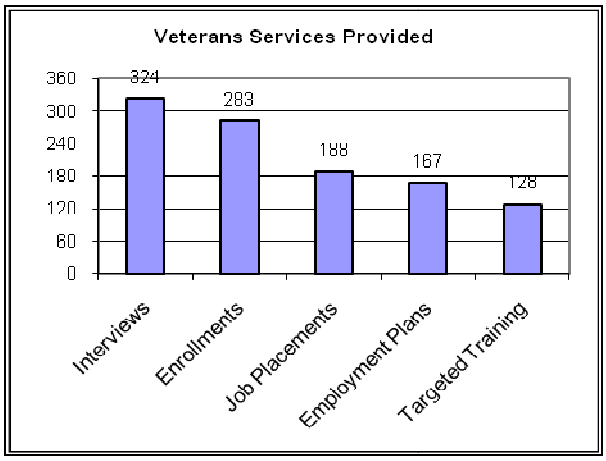
Performance: August 1, 2008 through December 31, 2010

1. 283 veterans were screened and referred to appropriate services
2. 188 veterans were placed in jobs or training opportunities

SERVICES PROVIDED

From project implementation in October 2008 through 2010, 283 veterans were screened and referred to appropriate services. Approximately 183 veterans were placed in jobs or training opportunities. Over 60 percent of the veterans served were single adults. Fourteen percent were homeless and 92 percent were unemployed.





MOST RECENTLY MEASURED OUTCOMES

One hundred eighty three clients have been placed in jobs, apprenticeships, internships or training opportunities. One hundred percent of those placed in jobs over a year ago retained them for 12 months.

Client Story

Greg (not his real name) was a veteran lacking job experience and frustrated with his career. The Veterans Conservation Corps (VCC) was able to enroll him in an Energy Auditing class at South Seattle Community College. The program also arranged funding to become certified as a Building Analyst. With these credentials, Greg was recently hired as an Assistant Energy Management Analyst at a local public utility.

Evaluation Questions

How was the program expanded or enhanced with Levy funding?

Levy funds were awarded to the Washington State Department of Veterans Affairs in October 2008 to implement the program. With the Levy funds, WDVA was able to assign a program coordinator to develop training, education, internship and apprenticeship opportunities for veterans in King County. In 2010, the King County VCC coordinator improved connections with the Vet Corps program and other organizations serving Afghanistan and Iraqi war veterans. These changes have resulted in successful placement of 10 Vet Corps members in King County colleges and other sites. These members leverage a great deal of assistance to the King County VCC program without additional cost.

Who has been served through this program?

Two hundred eighty three persons have been served. Ninety-two percent were unemployed and 79 percent were low income. The program is serving approximately 50 percent Iraq/Afghan war veterans and 50 percent veterans from earlier eras.

Sixty-one percent of the veterans served were single adults and 20 percent were in households with children. Fourteen percent were homeless. Clients were from throughout King County—45 percent south county, 35 percent Seattle, 13 percent east county, and 7 percent north county.

How effective have services been?

One hundred eighty eight clients out of 283 served were placed into internships, apprenticeships, educational programs or other training programs. The success is based on the ability of the King County VCC contractor to meet with veterans on their own turf, and then to facilitate connection to the opportunities that fits their needs, skills, and aptitudes. Moreover, the follow through and follow-up have provided a transitional program that supports the veteran through their initial stages of entry into the workplace.

The program followed up with 63 clients who had been placed in jobs at least one year before. All of the clients remained employed.

Are any changes in the program model anticipated?

The program will essentially remain the same although adding an additional program assistant is being considered in order to cut down on the significant mileage the contractor is now putting into the workweek.

Lesson Learned

1. Employment programs targeted to environmental stewardship and environmental jobs can be effective.
2. The face-to-face and “out in the community” activities that the King County VCC project coordinator has done have been the most effective part of this program. Without her willingness to meet veterans wherever and whenever (including evenings and weekends), the program would not have had as much success.
3. A key component of the program success has been the program coordinator’s outreach with referral sources such as the VA, community and technical colleges, apprenticeship programs, various employers, etc.
4. Follow-up with clients is crucial. Especially for vulnerable veterans (homeless or recently returning veterans with poly-traumas) follow-up is essential to assure follow-through and provide encouragement and guidance to them.
5. It is difficult to cover the entire county with one levy-funded position. The program coordinator does not have much time for each veteran. This may result in veterans dropping out if regular, frequent contact with program staff is not maintained.

STRATEGY 1, Activity 1.3

Provide Dedicated Phone Resources for Veterans

Purpose / Objective: Improve the quality and accessibility to appropriate resources by those in need through a dedicated phone line.

Activity 1.3 Develop a call-in telephone resource uniquely dedicated to veterans and veterans' services. This will improve referral and linkage to a broad range of regional housing, health and human services in King County.

Services Start Date: September 2010

Agencies funded: Washington State Department of Veterans Affairs (WDVA)

Performance Measures

1. 231 persons used the dedicated resource
2. 220 persons receiving referrals
3. 140 persons applying for and/or receiving needed services after referral by the dedicated phone system
4. Client satisfaction with information and services provided

SERVICES PROVIDED

The Washington State Department of Veterans Affairs was selected in 2010 to implement the veteran dedicated information and referral phone line. The phone line came on line in September 2010. By year's end, 231 persons had used the phone line. Fourteen service provider agencies had used the phone line.

MOST RECENTLY MEASURED OUTCOMES

Two hundred twenty out of 231 callers received a referral.

The number of callers applying for and/or receiving needed services after referral:

- Sixty-seven percent (140 of 210) of callers measured on outcome were successfully linked to services.

Client Story

None available at this time.

Evaluation Questions

How was the program expanded with Levy funding?

The Levy was used to fund the start-up and operation of a dedicated veterans call center. This included the development and maintenance of a database containing current veteran resource and referral information. The database is kept current and ongoing training is provided to staff on the contents of the database and its use in providing information and referrals to inquirers. The call center and phone line were opened in September 2010. Veteran Information and Referral Specialists operate the phone line during normal business hours, which are Monday through Friday, 8 a.m. to 5 p.m. The Specialists assess the callers' needs, identify appropriate services and resources, indicate organizations capable of meeting those needs, provide sufficient information about each organization to make an informed choice, and when necessary link the caller to needed services. Where possible, or desirable, three referrals are provided to give the caller a choice. Calls received after normal business hours are returned within one business day. The toll-free information and referral line has a 24/7 message capacity.

Who has been served through this program?

Two hundred thirty one persons have been served. Ninety percent of the callers were veterans, 7 percent were spouses of veterans and 3 percent were non-veterans. Eighty-two percent were unemployed and 53 percent were low income. Just over 50 percent were 55 years old or older.

How effective have services been?

The phone line saw increasing usage during the last three months of 2010. Eleven calls were received during the first month of operation. That grew to over 120 calls a month by December. Of the 231 callers, 220 (95%) received at least one referral. Follow-up was conducted with 210 callers of which 140 (67%) reported that they had successfully linked to the referred to services.

According to program management, the factors contributing to the phone lines effectiveness are:

- Knowledgeable Call Center staff with strong communication skills
- Excellent follow up customer service
- Regular communication with providers and networking
- Growing inventory of Veterans resources and services
- Continued marketing of service
- Competent WDVA staff onsite to support and assist Call center Staff

Are any changes in the program anticipated?

Given the constant changes in veterans and human services more time will be dedicated to research and maintaining an accurate resource data base. To promote this work the call center staff will be collaborating with the membership of the King County Veterans Consortium.

Lesson Learned

1. There are a high number of Veterans accessing the call center who are experiencing complex health, financial and family issues requiring significant staff attention and resources. Information and referral by itself is not sufficient to meet these callers' needs.
2. Employment related issues are an increasing area of concern for callers.

Strategy 2 Overview
Ending Homelessness through Outreach, Prevention, Permanent Supportive Housing and Employment

Objective: End homelessness for vulnerable at-risk individuals and families by providing resources that improve their ability to secure and maintain permanent housing.

Strategy overview: One of the greatest problems facing King County is the lack of safe, decent, affordable housing for the levy's target populations, including many veterans. Stable housing, linked to an array of needed supportive services, is critical to promoting housing success, recovery, and employment. The need for housing with support services is particularly acute for individuals who are high utilizers of hospitals, sobering services, and the criminal justice system, as well as for people who have been living on the streets or in shelters for extended periods, such as the chronically homeless.

A primary goal for levy investments is to help break the cycle of homelessness in ways specifically proven to help control the growth in costs in expensive after-the-fact health and criminal justice systems. Levy investments will expand the capacity to reach, engage, and house the most compromised homeless individuals and families throughout King County and get them on the road to housing stability. Resources have been allocated to accomplish three overarching objectives within Strategy 2, with a number of activities designed to meet the following objectives:

Partner in initiatives to identify, engage, and house long-term homeless populations

- Identify high utilizers of institutional resources to target with outreach and engagement.
- Develop expanded outreach and engagement for high utilizers and chronically homeless using the Dutch Shisler Sobering Center.
- Develop expanded outreach and engagement for high utilizers and chronically homeless – Seattle Racial and Ethnic Approaches to Community Health (REACH).
- Develop expanded outreach and engagement in South King County – Sound Mental Health.
- Develop expanded medical outreach and engagement in South King County – Mobile Medical Van.

Increase permanent housing with supportive services

- Develop increased permanent housing by providing capital funds for new permanent housing.
- Invest in Landlord Risk Mitigation Fund to increase access to private market rental units for formerly homeless individuals and families with barriers to housing.
- Invest in supportive services and operating costs for current and new permanent housing – Housing Health Outreach Teams (HHOT) (Public Health – Seattle & King County).
- Invest in supportive services and operating costs for current and new permanent housing – Housing and Human Services Fund (multiple homeless housing providers).
- Enhance the housing and supportive service program of the King County Criminal Justice Initiative for individuals with histories of mental illness and long-term homelessness.
- Invest in permanent housing placement supports for single parents with children with criminal justice involvement exiting transitional housing.

Prevent homelessness from recurring

- Invest in Housing Stability Program.

- Link education and employment to supportive housing.

How have levy resources been used to meet these objectives?

Most of the Strategy 2 activities build on programs or models that existed in the community prior to the availability of levy funds, such as the Homeless and Housing Services Fund. Funds were often blended with other housing and homeless services funding provided through the State of Washington Housing Trust Fund, King County document recording fees, United Way, City of Seattle, and other sources. Total levy expenditures through 2010 were $11,239,512 in Veterans Levy funds and $17,855,566 in Human Services Levy funds.

Table 2-3: Strategy 2 Levy Resource Used to Date

Activity		Lead Implementing Agency	Date of First Service	Clients through 2010[1]	How were levy resources used?	Expenditures though 2010
Identify and engage those who have experienced long-term homelessness						
2.1.A.1	Develop triage database identifying homeless high utilizers	MHCADSD	2010	**222**	Project funded development of a data strategy including a coordinator and IT database developer to create list of high utilizers and data collection protocols	$389,490
2.1.A.2.a	Service improvements for homeless Dutch Shisler Sobering Center/ Emergency Services Patrol	MHCADSD	July 2008	**5,519**	Expanded Emergency Services Patrol hours and trips to 24/7 coverage	$471,665
2.1.A.2.b	Outreach and engagement to chronically homeless - Seattle/REACH	PHSKC	January 2009	**989**	Expanded REACH outreach staffing by 33 percent in Seattle	$602,789
2.1.B.1	South King County outreach team PATH	CSD	July 2007	**1002**	Added outreach worker capacity in South King County	$511,756
2.1.B.2	Mobile Medical Unit	PHSKC	July 2008	**892**	Levy funds the team which includes a project manager, physician time, a medical assistant, an outreach worker, pharmaceuticals, and the costs of leasing and operating the van	$667,982
Increase permanent housing with supportive services						
2.2.	Increase permanent housing capital	CSD	Fall 2007	**TBD**	Capital funding provided for 543 units of housing via RFPs through 2009	$15,150,190
2.3	Landlord Risk Mitigation Fund (Landlord Liaison Project)	CSD	January 2009	**1544**	Created the Landlord Mitigation fund as a reserve for damages and repairs	$1,000,000 [2]
2.4.A	HHOT	PHSKC	January 2008	**2525**	Levy funding added staff to HHOT team and a nurse to south county team	$863,450
2.4.B	Investment in support services for housing	CSD	January 2008	**782**	Six housing agencies awarded support services funding to assist formerly homeless to succeed in permanent housing	$3,033,021
2.5.A	Criminal Justice Initiatives Forensic Assertive Community Treatment (FACT) Program	MHCADSD	July 2008	**132**	The levy pays for 40 percent of total program costs	$289,385
2.5.B	Criminal Justice Initiatives Forensic Intensive Supportive Housing (FISH) Project	MHCADSD	April 2009	**218**	New project entirely funded by levy (initially) pays for a six plus member professional team	$1,300,000
2.6	Permanent housing placement for Criminal Justice (CJ) involved parents	CSD	September 2008	**160**	Contract with two agencies to provide case management services to women exiting the criminal justice system	$124,179

[1] *May be duplicated when multiple years are combined*

[2] *The Landlord Mitigation fund is reserved to meet future needs, actual expenditures $38,820.*

Prevent homelessness from recurring						
2.7	Housing Stability Program	CSD	May 2008	**5,009**	Contract with 14 agencies to provide at-risk households with financial assistance and limited support services	$2,724,617
2.8	Link education and employment to supportive housing	CSD	August 2008	**2,059**	Contract with nine agencies to provide training and employment services for homeless and formerly homeless individuals	$2,927,733
Total Clients Served Through 2010				**21,053**	**Expended $ Through 2010[3]**	**$30,056,257**

How has levy funding contributed to ending or preventing homelessness?

Levy funds have significantly expanded homeless and housing services to vulnerable populations, active-duty military, veterans, and their families. While each activity's accomplishments are detailed in the reports in Section 3, some overall statistics offer insight into the levy's broad impact. Levy-funded activities have met the following results and intermediate outcomes:

Partner in initiatives to identify, engage, and house long-term homeless populations

Through 2010, over 2,500 isolated homeless individuals became enrolled or engaged in levy-funded outreach services as a first milestone in ending their homelessness.

Increase permanent housing with support services

- Over 1,916 formerly homeless individuals are maintaining their permanent housing though health care, case management, chemical dependency, and mental health treatment.
- A total of 1,226 permanent housing units have been created (or are soon to come online) to serve formerly homeless persons, including 178 units dedicated to serving homeless veterans.
- In addition, over 105 landlords (including 62 landlords who had not rented to formerly homeless persons) are now making 201 existing properties available to formerly homeless people thanks to the levy-funded Landlord Liaison Project and the Landlord Risk Mitigation Fund.

Prevent homelessness from recurring

Homelessness has been prevented for 551 veteran and 1,350 non-veteran households at risk of losing their housing. These households received short-term financial assistance that helped them handle an immediate crisis and enabled them to retain housing. Fully 93 percent of those who received this assistance were still in their housing six months later.

Each Strategy 2 activity that had been implemented by 2010 has a separate evaluation report presented in detail. The evaluation reports for Strategy 2 focus on overall performance results and highlights 2010 success rates and most recent demographics of clients served. Table 2-4 presents a summary of the total achievements through 2010 for each separate activity.

[3] *Differs from 2010 actual expenditures due to inclusion of Landlord Mitigation Fund reserve.*

Table 2-4: Strategy 2 Activity 2010 Performance

Activity		Clients Served through 2010[4]	Services		Outcomes	
			Types	Quantity through 2010	Outcome Measures	Most recent Results[5]
Identify and engage those who have experienced long-term homelessness						
2.1.A.1	Develop triage database identifying homeless high utilizers	222	Develop list of high utilizers Clients securing housing	5,305 HU 222	List developed Number HU getting housed	March 2010 222 Units filled
2.1.A.2.a	Service improvements for homeless Sobering Ctr/ Emergency Services Patrol	5519	Clients linked to support services	4,746	Increased engagement in services (individuals)	92.5%
2.1.A.2.b	Outreach and engagement to chronically homeless - Seattle/REACH	989	Clients enrolled	989	Clients retaining permanent housing Enrolled in benefits Improved MH status	79% 60% 45%
2.1.B.1	South County outreach team (Sound Mental Health)	1002	Outreach contacts Clients Engaged	1,152 712	Increased access to resources	%
2.1.B.2	Mobile Medical Unit	892	Referrals for assistance	1,831	Clients linked to treatment	87%
Increase permanent housing with supportive services						
2.2.	Increase permanent housing capital	TBD	Capital projects funded through 2010	25	Vets units funded Total non-vets units funded	178 1048
2.3	Landlord Risk Reduction (Landlord Liaison)	1544	Households served Hours of education-outreach	484 10,689	Percent of clients 1 year retention Landlords renting units	84% 105
2.4.A	Housing Health Outreach Team (HHOT)	2525	Linked to Primary Care MH/CD engagement Self-manage chronic condition	746 888 1189	Increase housing stability	97%
2.4.B	Investment in support services for housing	782	Households served Case management hours	722 48,769	Increase housing stability	86%
2.5.A	Criminal Justice Initiatives FACT Program	132	Client engaged in services Clients moved into housing	51 45	Move into supportive housing	88%
2.5.B	Criminal Justice Initiatives FISH Program	218	Client engaged in services Clients moved into housing	63 58	Move into supportive housing Retain housing 6 months	58 76%
2.6	Permanent housing placement for Criminal Justice (CJ) involved parents	160**	Families enrolled Case management hours	93 7273	Reunify with children and Increase housing stability	57%
Prevent homelessness from recurring						
2.7	Housing Stability Program	5,009	Households assisted	1,901	At-risk families who maintain their housing 12 months	93%
2.8	Link education and employment to supportive housing-Community	1,937**	Clients enrolled	1931	Secure job/Meet job goals Retain jobs/Increase income	414 61%
2.8 B	Link education and employment to supportive housing – WTP	122	Clients enrolled	122	Meet IAP plan objectives Those securing jobs retain jobs	104/86% 79%

** Outcome measurement results are based upon the number of clients eligible to be measured, which is likely to be different from the number of clients served in 2010. For projects marked "**" clients served include all members of the household.

What lessons have been learned?

Although each activity has helped us learn very specific lessons, we have also learned some broadly applicable lessons during the first three years of levy implementation. These offer useful guidance as we strive to end and/or prevent homelessness.

[4] *May be duplicated when multiple years are combined*

[5] *Results are a percentage of successfully measured for outcome these are the most recent (2010) success rates.*

- Prioritizing services for people who are homeless who are high utilizers of services, vulnerable, and/or chronically homeless has challenged projects to be creative and fluid in how they engage these clients in services, and for how long services are provided. Each project has had to modify approaches depending upon such factors as gender, level of vulnerability, mental health or co-occurring disorders, isolation, rural or urban setting, and the availability of special needs housing resources.
- Outreach and housing support service approaches for the chronically homeless have required staff with a high degree of professional and relationship-building skills, and called for intensive multi-disciplinary approaches to assist clients to get and maintain the care and housing they need.
- Throughout all projects, especially employment, interagency coordination that links programs able to provide skilled specialized staffing and resources for clients has been essential and improved each project's ability to serve clients effectively.
- The lack of available and appropriate affordable housing continues to be an issue in achieving the project's long-term outcomes to end homelessness.
- Levy-funded housing units are serving clients with a variety of needs, but the overall funding dedicated to new unit development is not keeping up with demand. Strained government budgets and rising construction costs will continue to put pressure on development of new units for vulnerable populations.
- In light of the challenge for new housing units to keep pace, it is essential to find ways to overcome client barriers to accessing private market housing. Building and maintaining positive relationships between different support services providers and landlords has been essential to securing housing opportunities for many homeless persons who have barriers to private market housing.
- Veterans Levy funding has increased awareness of veterans' involvement in the county's homeless services system. The percent of veterans who are homeless and involved in King County service systems was initially overestimated. Many special outreach or new veteran-focused resources have been necessary to engage veterans in community services systems and meet service targets.
- The veterans who have been served are primarily older veterans, with few younger OEF/OIF veterans being seen in the service system. This is believed by veterans' service professionals to be due to the delayed onset of the detrimental effects of PTSD on a person's ability to maintain housing stability.
- Longer-term household stability outcomes are difficult to measure in the timeframe of the current levy.

Strategy 2, Activity 1.A.1
Develop list for high service utilizers for coordinated support services

Objective: End homelessness for vulnerable, at-risk individuals by providing resources that improve their ability to secure and maintain permanent housing.

Activity 2.1.A.1: Identify high utilizers of institutional resources to target with outreach and engagement. Create a coordinated database that will identify for priority services homeless individuals who are high utilizers of sobering services, courts, jail, and the health system.

Agencies funded: Mental Health, Chemical Abuse and Dependency Services Division (MHCADSD)

Services start date: June 2008

Performance 6/2008 – 12/2010

- A list of 9,000+ client records has been created and maintained.
- In collaboration with Client Care Coordination, the housing providers and referral sources, 831 potential tenants were identified as meeting system utilization and/or vulnerability requirements for the various housing projects. Of these, 222 were selected to move into the new service enriched housing units.
- Approximately 57 percent of those on the list have reported use of services and assigned a score that is used for priority housing placement.

Services provided

The High Utilizer Integrated Database Project was initiated to extract client-level data from expensive county services that serve chronically homeless individuals and thereby identify high-level users of these services. The levy-funded IT staff on the database project have developed a centralized repository of client information by collecting client data sets from several existing databases, including but not limited to the mental health, Dutch Shisler Sobering Center, Safe Harbors, VA, state hospital, community hospital, and King County Jail information systems.

The integrated database is a resource to any publicly funded housing program that provides services to the target population. The database is currently being used to create a triaged list of the homeless high utilizers of sobering, courts, jails, and the health system, and to coordinate their entry into an array of existing and new set-aside housing units, housing vouchers, or other placements.

King County outreach and engagement programs for high utilizers and/or chronically homeless individuals are being reorganized into a new Client Care Coordination model that links referrals from outreach and support services programs into permanent housing placements. The integrated database of high utilizers/chronically homeless is a tool that will help the Client Care Coordination team as they develop client candidate lists for King County and Seattle permanent supportive housing projects.

Most recent measured outcomes – 2010

The original database of high utilizers has been created using data from MCHADSD, King County Jail, and the Dutch Shisler Sobering Center. The project will ultimately incorporate data from hospital emergency departments, Safe Harbors HMIS, municipal jails and Western State Hospital. The project has assigned service utilization scores to over 5,000 clients based upon the 2010 data set.

Evaluation questions

How was the program expanded or enhanced with levy funding?

The project is funded entirely with levy funds.

Who has been served through this program?

This activity addresses the unmet needs of adults who are chronically homeless, experience mental illness and/or substance abuse, and are frequent users of emergency services, hospitals, jails, shelters, sobering and/or detox centers. In 2010, the project provided client candidate lists for seven new permanent supportive housing projects: Sophia's Way, Humphrey House, Scargo, Compass-Renton, valley Cities landing, Rose of Lima, and Canaday House. In collaboration with Client Care Coordination, the housing providers and referral sources, 831 potential tenants were identified as meeting system utilization and/or vulnerability requirements for the various housing projects. Of these, 222 were selected to move into the new service enriched housing units.

Lessons learned

- It has taken a great deal more effort to negotiate the data sharing agreements than originally expected, particularly in working with health providers or HIPAA constraints. There have been competing privacy regulations and data element definitions depending upon the data sources (jail versus emergency room, etc.).
- The project has dealt with significant technical challenges mapping and translating data sets.
- The concept that a one-time application could be created and then self-managed has turned out not to be true. Managing the data, creating client candidate lists, and analyzing data will require ongoing work.

Are any changes in the program model anticipated?

Efforts are underway to incorporate the standardized vulnerability scores into the integrated database and display both client utilization and client vulnerability scores in client candidate lists. The addition of the vulnerability scores is another means of assuring that those most at risk are those who are identified for service-enriched housing. This work is closely coordinated with Strategy 5.8.b (Vulnerability Assessment Tool (VAT) Implementation) that funds a training process for members of the provider network to use the standardized validated assessment tool developed by Downtown Emergency Services Center (DESC).

Strategy 2, Activity 1.A.2.a
Selected service improvements to chronically homeless – Seattle Emergency Services Patrol and outreach

Objective: Develop expanded outreach and engagement for high utilizers and chronically homeless in Seattle.

Activity 2.1.A.2.a: Link high utilizers and chronically homeless substance abusers in Seattle to engagement programs and housing placements to reduce homelessness and excessive use of expensive services.

Services start date: June 2008

Agencies funded

MHCADSD Pioneer Human Services – Dutch Shisler Sobering Center
King County Emergency Services Patrol

Performance 6/2008 – 12/2010

- Since June 2008, the Emergency Services Patrol has transported 5,519 clients to the Dutch Shisler Sobering Center.
- Of those transported, 4,746 were linked to supportive services.

Services provided

This activity combines a number of Seattle-based activities working with high utilizers/chronically homeless individuals who are involved with substance abuse treatment or who are connected through outreach services. Portions of the levy-funded services include:

- King County Emergency Services Patrol, which picks up intoxicated people from downtown streets and transports them to services.
- Dutch Shisler Sobering Support Center, which provides a safe place to sleep off the effects of intoxication.
- Client Care Coordination, which brings together a variety of outreach and social services workers to coordinate care for high-utilizing homeless clients.

Most recent measured outcomes – 2010

A total of 1,885 clients were transported by the King County Emergency Services Patrol in 2010, of whom 1,744 (92.5%) were connected with supportive services.

Client story: The Emergency Services Patrol worked with a 55-year-old Caucasian male during the year, first to transport him to and from sobering services. The client was housed during November, but had a difficult transition, preferring to stay with his social group at a tree camp off Aurora. The ESP team worked with his case manager and housing provider to identify the location and patrol the area every shift, stopping to engage the client and his friends. It took a month to get him oriented towards his housing, a

process that included engaging his peer group in encouraging him to take the van home. He is now mostly absent from the camp spot and using his apartment.

Evaluation questions

How was the program expanded or enhanced with levy funding?

The Emergency Services Patrol continued with expanded hours of operation of its van 24 hours per day, seven days per week. The additional hours created the capacity to transport clients from the Sobering Center to other services during the day. The traditional catchment area has been expanded to serve the VA Center on Beacon Hill and the Cherry Hill Campus of Swedish Medical Center.

Who has been served through this program?

Limited information is recorded on the clients of the ESP as they sleep off their inebriation. However:

- All those who were transported to services were homeless.
- All individuals served were over 18.
- Approximately 90 percent of those served were male.

Lessons learned

- The expanded hours to include daytime transportation are essential to enable clients to connect to daytime services and support as they sober up.
- Coordinating all of the care and outreach services has improved providers' ability to help clients move from chronic substance abuse into treatment and housing.
- The lack of available and appropriate affordable housing continues to be an issue in achieving project outcomes.
- The Sobering Center's efforts to reduce continual excessive use of sleep-off were demonstrated during 2009. In 2008, 12 individuals stayed at Sobering 175 times or more, with the highest utilizer in the facility 274 times. In 2009, no single client had 175 or more admissions.

Are any changes in the program model anticipated?

There are no changes anticipated at this time.

Strategy 2, Activity 1.A.2.b
Selected service improvements to chronically homeless – Seattle REACH outreach

Objective: Develop expanded outreach and engagement for high utilizers and chronically homeless in Seattle to reduce risk and use of expensive services.

Activity 2.1.A.2.b: Link high utilizers and chronically homeless substance abusers in Seattle to engagement programs and housing placements through the REACH outreach team.

Services start date: January 2009

Agencies funded

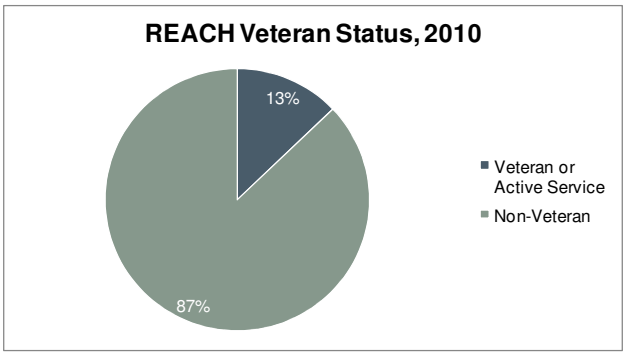
Public Health - Seattle & King County, Evergreen Treatment Services, REACH Project

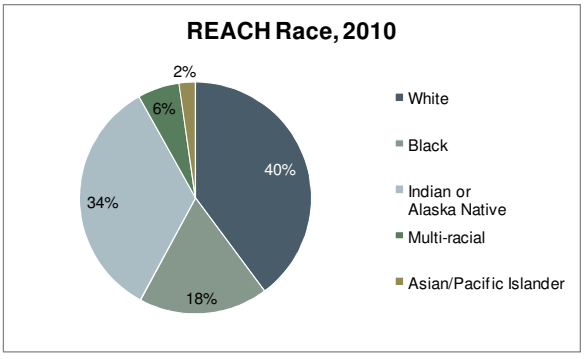
Performance 1/2009 – 12/2010

- A total of 989 clients were engaged in REACH services since January 2009.
- A total of 504 clients improved or maintained their housing situation (51%) and 275 (28%) moved into permanent housing.
- Approximately 450 REACH clients (46%) participated in addiction treatment.
- A total of 533 clients (54%) of the caseload obtained health coverage and/or entitlements, with 267 of case managed clients receiving disability income.

Services provided

The REACH team used levy funds to expand outreach to chronically homeless and high utilizers throughout Seattle. Services include outreach and engagement in outdoor sites such as greenbelts, alleys, and under bridges; and intensive case management for the most frequent and/or vulnerable users of the Sobering Center. The REACH staff engage clients and work to provide access to housing, benefits and entitlements, substance abuse services, and community-based health services. The REACH staff work with clients on the application process for income benefits and entitlements.





*Hispanic calculated separately: 47 clients in 2010 (10 percent) were identified as Hispanic.

Most recent measured outcomes – 2010

- A total of 487 clients were engaged in REACH services in 2010.
- A total of 262 clients improved or maintained their housing situation and 148 (30%) moved into permanent housing.
- Forty-four percent of the REACH clients enrolled in substance abuse treatment.
- A total of 294 clients (60%) of the caseload obtained health coverage and/or entitlements, with 112 (34%) of case managed clients received disability income.
- A total of 379 clients received one or more health services: 131 received services from the REACH nurse, 217 were linked to primary care services, 215 were linked with episodic health care, and 42 were linked to dental services.

Client story: When Jane was first engaged by a REACH outreach worker, she was sleeping outside under bridges, concrete pipes by the railroad or "in the Jungle" and had been homeless for over 30 years. She fed herself by getting food out of dumpsters and poor nutrition contributed to her health problems. She had a reputation on the street and had a long history of violence and substance abuse. A chronic alcoholic; she used crack cocaine and heroin when it was available. Her REACH case manager said, "even *we* were a little intimidated initially because she was a six foot tall, boisterous Native American woman who was always covered in a huge black hood. Frequently we couldn't see her face, so it was difficult to predict what kind of state we were going to find her in." The REACH outreach nurse started with treatment of her swollen legs and gave her new socks and shoes to relieve some of the pain she had experienced for years. After many months, the nurse introduced her to a REACH case manager, who also spent months building a relationship, until Jane agreed to work with both of them on addressing some of her issues. Together they made a plan with Jane to seek ongoing health care, maintain her DSHC benefits and find housing. She went with the case manager to the Pike Place Medical Clinic. Moreover, when supportive housing units came available at DESC's Canaday House, Jane applied and was accepted. She said the last time she had a roof over her head was in prison and cried when she took the keys to her apartment.

Jane has remained in housing for almost 5 months with no problems and pays her rent on time each month. She has improved her health by attending her medical appointments, taking her medication daily, improving her nutrition and gaining needed weight. She has reduced her alcohol consumption by almost half when compared with what she was drinking on the street and her illicit drug use has ceased. Jane has not been in jail for several months, has not shown any violent behavior and continues to work to improve her life. She shows up for appointments with her REACH case manager, follows through on steps necessary to get SSI, and at every visit, she expresses gratitude for the help she has received from the REACH team.

Evaluation questions

How was the program expanded or enhanced with levy funding?

The REACH project had six Full-time employees (FTE) outreach workers and case managers. The project was expanded with levy funds to add an additional two FTE case managers and one FTE outreach worker.

Who has been served through this program?

The population focus for this strategy area is homeless individuals in Seattle who experience primary substance abuse disorders, and who may or may not have co-occurring mental disorders. Clients are referred from the Dutch Shisler Sobering Center, the outreach team, medical respite, Chief Seattle Club,

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First Avenue Service Center, and Angeline's Day Center. All clients were homeless at intake. The other clients were homeless when first on the REACH caseload, but had moved to permanent housing and still required the support of a case manager. Most recent demographic data (2010) show:

- Most clients are between the ages of 35 to 54 (332 clients) and 78 percent of REACH clients were male.
- A total of 60 percent of REACH clients were persons of color, and 34 percent of the total case management caseload was Native American, higher than shelter averages mainly due to linkages through the Dutch Shisler Sobering Center and the Chief Seattle Club.

Lessons learned

- The team's home base moved from the Dutch Shisler Sobering Center to the Markham Building in Belltown in 2009. The REACH continues to provide services at the Dutch Shisler Sobering Center and has maintained a client caseload similar to past years.
- The REACH team has been successful at engaging clients and overcoming client wariness. This is believed to be due to the non-judgmental approach the workers use.
- The project has been successful at improving client public health outcomes. As with the mobile medical van, offering on-site health care is a successful engagement tool for many clients.
- The multi-disciplinary approach of nursing, social work, benefits case work, and case management is successful at engaging clients because the REACH project can offer an array of services to a client.
- The REACH project is successful at developing relationships with landlords on behalf of clients. This has allowed them to get clients into scattered site housing much like the landlord liaison project model.

Are any changes in the program model anticipated?

There are no substantive changes anticipated at this time.

Strategy 2, Activity 1.B.1
PATH Outreach Team

Objective: Connect or reconnect homeless persons in South King County to services and housing.

Activity 2.1.B.1: Develop expanded outreach and engagement through the PATH program.

Agencies funded: Sound Mental Health

Services start date: October 2007

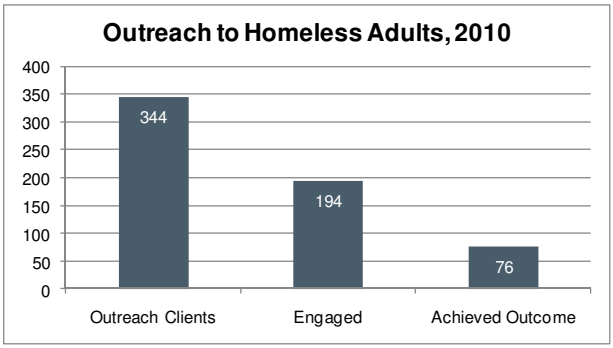
Performance 10/2007 – 12/2010

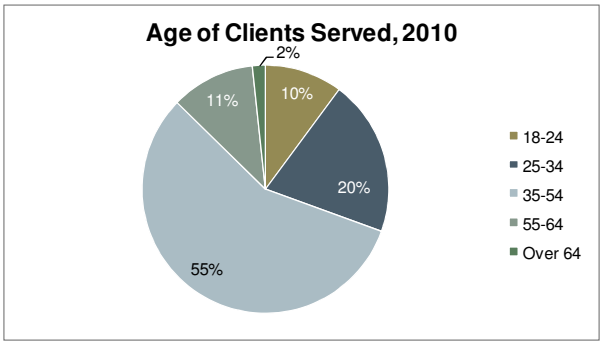
- The PATH program worked with 1,002 persons, and was able to engage 712 clients long enough to establish them as clients.

Services provided

The PATH outreach team seeks and engages homeless adults in South King County, with a priority on those who have been homeless for a long time and may have mental health, substance abuse, and other problems. While this project was originally intended to coordinate services for clients served by the mobile medical van, it now provides direct referral to community clinics.

Outreach is particularly important, because those who have been chronically homeless, especially those with serious disabling conditions and/or long-term homelessness often have difficulty finding or accepting the services and care they need. Outreach workers engage people who are homeless. They slowly gain their trust, and support them in accessing the services and housing they need. Connection to housing and housing stability is the ultimate goal. Other positive outcomes include enrollment or reconnection with the mental health system, enrollment in benefits (such as veterans' benefits or social security), and connection with a primary health care provider.





Most recent measured outcomes – 2010

In 2010, seventy-eight percent of clients (76 of 97 clients eligible for measurement) achieved at least one of the following: improvement in their housing stability, enrollment in primary health care, enrollment in chemical dependency treatment, enrollment in mental health services, or increase in income.

Client story: Jearlean is a veteran who served in the Army from 1978 to 1992. When she was contacted by the outreach team, she had been homeless for about four years. She was living behind a small shopping mall in a camp called the wetlands just off Pacific Highway South. Jearlean had been

hospitalized at Harborview in 1990 for an episode, likely a psychotic break. She had been abusing alcohol for 15 or more years, and smoking marijuana and crack cocaine when it was available. Jearlean was very hard to engage; she was anxious and distrusted the outreach efforts. She would disappear for weeks and then turn back up. It took more than five months to gain her trust and place her in housing.

Jearlean moved into her apartment, but continued to hang out with her homeless friends, partying with them to the point of having the police intervene. Her case manager helped her reduce the disturbances. Jearlean was evaluated for physical and mental health issues and currently receiving medication to reduce her anxiety symptoms. She has had a chemical dependency evaluation and is working with her case manager on her issues. In short, she has stabilized and sees her case manager three to four times a week in her home. She is calm and happy in her apartment, and grateful for it.

Evaluation questions

How was the program expanded or enhanced with levy funding?

The federal government originally created PATH teams that performed street outreach to specific eligible populations (homeless persons with mental health issues). Levy funds have permitted King County to fund additional outreach workers and expand the definition of eligibility to include homeless persons with addictions, with or without mental health issues. Outreach extended to the mobile medical van, shelters, food banks, libraries, church feeds, encampments and areas where homeless individuals congregate.

Who has been served through this program?

The PATH program worked with 1,002 persons, and was able to engage 712 clients long enough to establish them as clients. Most recent demographics (2010) show that:

- Two-thirds of all clients were homeless.
- Slightly over half (55 percent) of those engaged were 35 to 54 years old, 30 percent were 18-34 years of age.
- A total of 12 veterans were served. The actual number may be higher, but information was collected only from those with a longer engagement with staff.

Lessons learned

- The team continues to address the issue of caseload to balance new outreach with service to those already on the caseload. Building trust takes time and requires a consistent presence. Outreach case managers must search people out and expect that often they will not show up at an agreed place and time. These clients have many needs to be addressed, and they need support throughout the process.
- Rural outreach is challenged by transportation barriers to getting clients from the streets to where services are located.
- The lack of available and appropriate affordable housing continues to be an issue.
- There is an ongoing need for strategic coordination of services: A system-level, strategic oversight group was created last year to address outreach in South King County. King County staff, HealthPoint social workers, Valley Cities Counseling and Consultation, Sound Mental Health, the City of Kent and mobile medical van staff participate. This group shares information and helps with problem solving.

Are any changes in the program model anticipated?

There has been a shift in the model being implemented by the mobile medical van, and so the relationship between this outreach project and the van has changed as well. Sound Mental Health outreach workers take informal referrals from van staff as appropriate, rather than being part of the van's formal protocol for referrals and case conferencing.

Strategy 2, Activity 1.B.2
Mobile medical unit

Objective: Connect or reconnect homeless persons in South King County to needed medical and support services through expanded mobile medical capacity, assessment, and referral to services.

Activity 2.1.B.2: Develop expanded medical outreach and engagement in South King County through mobile medical van operated by Health Care for the Homeless.

Agencies funded: Public Health - Seattle & King County Health Care for the Homeless

Services start date: November 2008

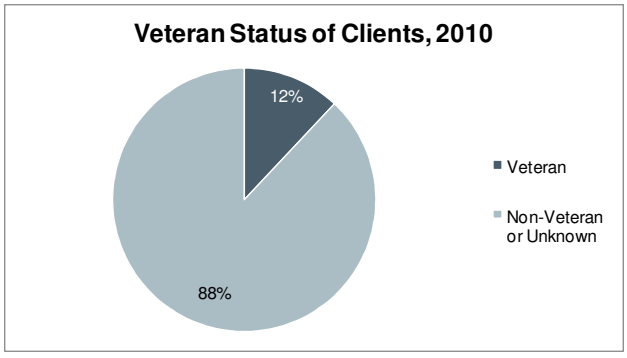
Performance 11/2008 – 12/2010

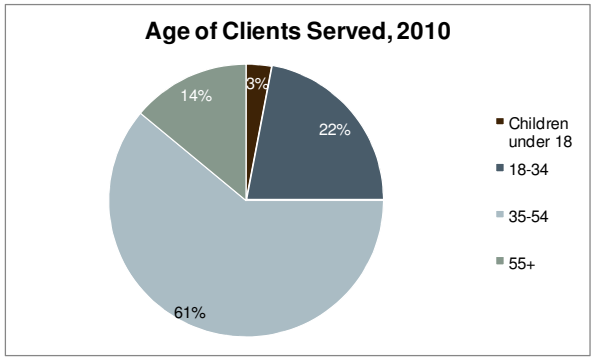
- A total of 892 clients received medical services provided through the mobile medical van.
- A total of 1,831 referrals for assistance were made.
- Over 83 percent of the clients served were homeless.

Services provided

The program's mobile medical van holds regular clinics in Federal Way, Kent, Renton, Tukwila and Auburn. The program reduces barriers to access by offering all services on a walk-in basis at locations to which many of the most vulnerable homeless people in the community are already traveling to eat lunch or dinner. Walk-in services include primary and preventive medical care, clinical assessment for mental health and chemical dependency treatment, dental care, and help navigating medical and disability benefits programs and other safety net health and social services systems. Outreach workers teamed with the medical van at each meal program explain these services to people identified as homeless. Program staff members place special attention on engaging the many unsheltered, chronically ill people at these meals who have no income, insurance, or regular source of medical care. The outreach team explains the program's open door philosophy and strives to build trusting relationships to encourage people to engage in services.

Immediately following a visit with a program doctor or dentist, program clients are introduced to a team member who can help establish a connection to a local community health center for follow-up and ongoing primary care. Most patients are also introduced to other team members who can help them with medical benefits, housing, mental illness or addiction issues, and other common needs.





Most recent measured outcomes – 2010

The measured outcomes for this activity are number of clients assessed and referred to health and mental health services, number of clients successfully linking and receiving primary care or mental health services.

Clients had a total of 1,249 visits with a program doctor, dentist, or psychiatric social worker, including 519 doctor visits, 168 dental visits and 562 psychiatric social worker visits. Of the one-third of program clients completing a psychiatric assessment, over 40 percent subsequently attended at least one behavioral health appointment at a nearby community health center and over 20 percent started psychiatric medications.

During 2010, a total of 479 clients received medical services provided through the mobile medical van.138 mobile medical clinics and 24 mobile dental clinics were offered.

During the second half of 2010, more than one-fourth of program clients received assistance from the new medical benefits case manager. Of those program clients assisted by the medical benefits case manager, almost 40 percent successfully applied for Medicaid, ADATSA, or other medical benefits.

Client story: Daryl is 52-year-old African –American man who had been homeless for 4 ½ years and was living in an abandoned garage when he first encountered the mobile medical van outside the Salvation Army dinner in Renton in October 2010. In the 1980s, Daryl was diagnosed with severe asthma, epilepsy, a heart murmur, and depression. He had gone without any medical care or medications for many years. After hearing from a Mobile Medical Program outreach worker about the program's services, Daryl walked out to the van and met with the doctor, the psychiatric social worker, and the medical benefits case manager. While on the van, he decided to accept the team's offer to help him first apply for the State ADATSA benefits that would pay for alcohol treatment and then locate a treatment program. On Christmas Eve, Daryl entered a 28-day residential treatment program and after completing, the program immediately moved into a Clean and Sober Housing facility and began outpatient follow-up treatment. As he was leaving the residential facility, he called the Mobile Medical social worker to let her know of his progress and to ask about an appointment for follow-up care for his depression and other chronic illnesses. The social worker made Daryl an appointment with a primary care provider at a HealthPoint community health center close to where he lives. In addition to addressing his long-term medical issues, HealthPoint staff has begun helping Daryl look into options for housing into which he could transition when he finishes the 90-day stay at the Clean and Sober facility. When asked about his personal journey over the past three months, Daryl said, "When I look at where I am now versus where I was, I can't express how grateful I am to the staff on the medical van and all of the other people who made the program possible."

Evaluation questions

How was the program expanded or enhanced with levy funding?

The project began in 2008, and funded by the levy in its entirety. It includes a project manager, physician and dentist time, a nurse, an outreach worker, pharmaceuticals, and the costs of leasing and operating the van. The project has expanded services substantially each year and in 2010, served 46 percent more clients than in 2009. It added both clinic sites and services to address gaps identified during the first 14 months of its existence. Levy funding helped to leverage other grants that pay for a new robust mental health component and greatly expanded dental services.

Who has been served through this program?

The project held 138 mobile medical clinics and 24 mobile dental clinics were and served 479 (unduplicated) people during 2010.

- Eighty-three percent of persons served were homeless.
- About one third of the clients have been women, which is somewhat higher than most outreach conducted with homeless single adults (i.e., 38 percent compared with REACH at 25 percent).
- The project serves a broad range of age groups, with 14 percent over 55 and 22 percent between 18 and 34.

Lessons learned

- Transportation barriers make it difficult for clients to reach community social services. It is essential to introduce a disabled client to a friendly face and establish rapport while at the mobile medical site.
- Psychiatric social work must be co-located with the medical team. Early referrals to services were monitored and clients were not very successful at keeping appointments. Based upon the evaluation of results, the program changed its strategy and added a full-time social worker on staff rather than depending on another community-based provider for assessment and referral. The project also added a mobile psychiatric assessment and case management system using federal stimulus funds.
- Clients are seldom engaged in community services. Many of the veterans are disillusioned with the VA.
- Addition of dental services increased new clients' interest in mobile medical van services.
- The social worker has been overwhelmed by the number of new clients as the program becomes more successful at engaging clients.
- The addition of a benefits specialist in May 2010 will provide a significant benefit to clients.

Are any changes in the program model anticipated?

No major changes to the model are anticipated in the next 12 months. Adjustments in 2011 will include working more closely with the King County Client Care Coordination program to screen medical van clients for permanent supportive housing units reserved for people whose medical and social circumstances make them especially vulnerable.

Strategy 2, Activity 2
Increase permanent housing with support services (capital projects)

Objective: Increase the number of permanent housing units available to serve homeless individuals.

Activity 2.2: Increase the number of permanent housing units available by providing capital funds to create new units of affordable housing.

Agencies funded: Archdiocesan Housing Authority, Catholic Community Services, Community Housing Mental Health Agency, Compass Center, Downtown Emergency Service Center, Foundation for the Challenge, Friends of Youth, Highline West Seattle Mental Health, Low Income Housing Institute, Plymouth Housing Group, Sound Mental Health, St. Andrew's Housing Group, Valley Cities Counseling and Consultation, Vashon HouseHold, YWCA of Seattle-King-Snohomish Counties.

Services start date: Fall 2007

Performance through 2010

- One hundred seventy-seven housing units funded for veterans.
- A total of 1226 housing units funded for formerly homeless persons.

Services provided

This activity is intended to provide capital funding for increasing the affordable housing stock specifically to create housing that serves:

- Veterans in need and their families, who are struggling with or at risk for mental illness, health problems, PTSD, unstable housing or homelessness, and underemployment
- Individuals and families who have experienced long-term homelessness and are frequent users of emergency services, jails, and other institutions
- Individuals who have been recently released from prison or jail and who are striving to maintain their family or re-unite with children or other family members
- Families and children at risk of homelessness and involvement with justice, child welfare, and other systems.

The following projects were completed during 2010 (Total project units):

- Low Income Housing Institute – McDermott Place (76 units)
- Downtown Emergency Service Center – Canaday House (83 units)
- NAVOS – Burien Heights Residences (22 units)
- Foundation for Challenged – Foundation for the Challenged IV (6 beds)
- Plymouth Housing Group – Scargo Apartments (46 units)

The most recent RFP process was conducted in fall 2010. It was used to award $650,000 of Human Services Levy and $600,000 of Veterans Levy funds. Five projects received funding, including: Low Income Housing Institute – Jackson Street Senior Housing; Downtown Emergency Service Center – Aurora Supportive Housing; Terry Home – Terry Home II; Low Income Housing Institute – Bellevue Apartments; and Downtown Action to Save Housing – Evergreen Court.

Projects that were awarded funds in 2009 made significant progress toward completion in 2010 and the following projects will be occupied by the end of 2011: St. Andrew's Housing Group –Francis Village Apartments; St. Andrew's Housing Group – Andrew's Glen Apartments; YWCA of Seattle-King-

Snohomish Counties – Family Village at Issaquah Highlands; LIHI – White River Gardens; and Compass Center – Ballard Project.

Most recent measured outcomes – 2010

- A total of 177 veterans' units funded.
- A total of 47 human services units funded.

Evaluation questions

How was the program expanded or enhanced with levy funding?

Levy funds enabled a new dedicated source of capital funding for homeless veterans' housing and replaced critical capital funding lost through budget cuts, including $1 million from the Housing Opportunity Fund. The levy was key to funding more homeless housing and veterans' housing, especially within Seattle.

Who has been served through this program?

Units are set aside for veterans with very low-income (most less than 30 percent Annual Median Income) and verified in annual compliance reports.

Lessons learned

- Because local funding sources fluctuate based on tax revenues and federal sources of capital funding are currently flat, continuing economic and budget difficulties will likely mean less funding available for capital and new projects dedicated to serving veterans and the homeless.
- Housing units are serving a wide range of needs, but the funding dedicated to new unit development is not keeping up with demand. Strained government budgets and rising construction costs will continue to put pressure on development of new units for vulnerable populations.

Are any changes in the program model anticipated?

No changes in the model are anticipated.

Strategy 2, Activity 3
Landlord Risk Reduction Fund

Objective: End homelessness for vulnerable, at-risk individuals and families by providing resources that improve their ability to secure and maintain permanent housing.

Activity 2.3: Provide funds that maintain or increase the number of affordable permanent housing rental units accessible to homeless individuals by increasing the number of landlords willing to rent to formerly homeless households through the Landlord Liaison Project (LLP).

Agencies funded: YWCA

Services start date: January 2009

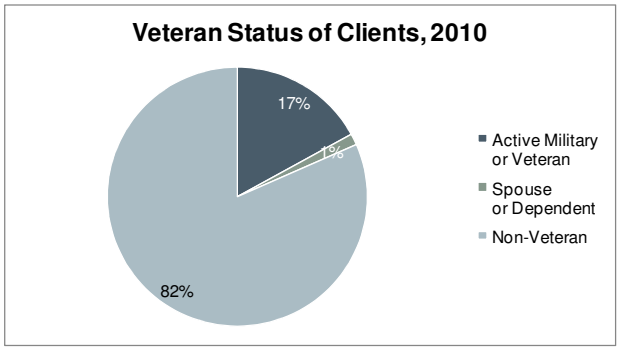
Performance 1/2009 – 12/2010

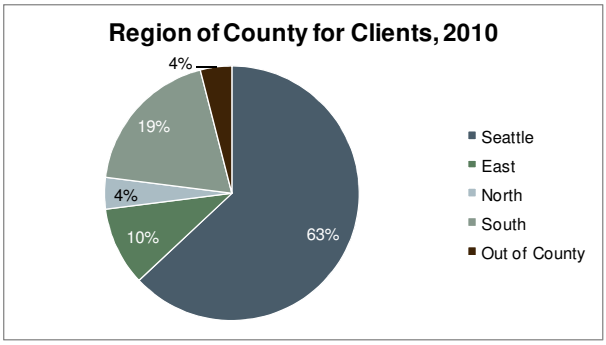
- A total of 484 households were served, including a total of 1,544 individuals (may be duplicated when multiple years are combined).
- To date, 86 percent of all households have maintained their housing stability for one full year.
- A total of 105 landlords have signed up with LLP to provide housing units.
- Risk reduction funds for $40,120 for damages beyond the amounts covered by a security deposit have been spent for 31 units since the beginning of the program.
- A total of 20 percent of all households are veterans or their dependents.

Services provided

The Landlord Risk Reduction Fund is a key component of the Landlord Liaison Project and a primary incentive to encourage landlords to rent to clients with poor credit and rental histories. The fund is a damage reserve fund that provides added assurance to landlords by offering them the option to be reimbursed for excessive damages beyond the amounts covered by a security deposit.

The LLP reduces barriers to entering permanent housing for homeless persons and provides supports to help them maintain housing and increase their stability over time. The LLP provides support to help landlords mitigate the impacts of reducing entrance criteria in order to house homeless persons, who have screening barriers due to past evictions, poor credit, and/or criminal histories that prevent them from obtaining affordable housing in the private rental market.





Measured outcomes to date

The success measure is to expand housing to persons who are homeless by convincing landlords to rent to formerly homeless individuals with barriers to obtaining housing.

- The LLP has signed up 105 landlords and property management companies as partners.
- A total of 905 individuals (in 484 households) have been housed through the LLP.
- To date, 86 percent of all households have maintained their housing stability for one full year.

Client story: Stephanie was in jail when she discovered she was pregnant and decided she had to turn her life around. While undergoing two years of intensive inpatient and outpatient therapy to recover from drug addiction, she went through the Community Jobs Program, had an internship at Goodwill, and completed her Administrative Office Professional Certificate at the Seattle Vocational Institute.

Stephanie knew she would have a difficult time getting an apartment on her own. The LLP helped her secure a two-bedroom apartment by paying her application fees. This winter, Stephanie is starting classes at Highline Community College to get her Associate's Degree as a chemical dependency specialist. In August, when she completes her second year of sobriety, she is hoping to secure a job at a nearby recovery center. She is especially interested in working with teens.

Evaluation questions

How was the program expanded or enhanced with levy funding?

The creation and availability of the $1 million Landlord Risk Reduction Fund was a key factor in encouraging landlords to rent to homeless households, which helped initiate the LLP.

Who has been served through this program?

The LLP serves three main constituency groups: tenants, landlords, and partnering social service agencies.

- Of the 484 households served, LLP has served almost an equal amount of families and single adults.
- A total of 56 percent of households are chronically homeless or have been homeless for a long period.
- A total of 20 percent of all households are veterans or their dependents.

How effective have services been?

The project has been seen as a valuable resource in serving persons who have screening barriers to obtaining housing. It has brought reluctant landlords into the mix, including landlord partners who would not have rented to homeless persons without the assurances provided by LLP.

Lessons learned

- Because the program model is working so effectively, landlords have not needed to file many claims to access the fund.
- LLP Risk Reduction Funds have been spent to avoid evictions in the case of incarceration, damages due to behavior or circumstance (wheelchair damage to walls, damage inflicted due to mental illness), hoarding and other damage beyond normal wear and tear. In 2009, only $2,663 in Risk Reduction Funds for five cases was needed. In 2010, the Fund was used in 26 cases for a total of $37,457. Allocation of these funds is judicious, and the yearly amount is not expected to increase

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- The LLP's ability to serve more homeless persons is limited by a lack of access to rental housing subsidies and support services needed to move households with significant housing barriers into the private rental market.

Are any changes in the program model anticipated?

The LLP will continue to serve higher-barrier households, and will serve more veterans through the Veterans Administration Supportive Housing voucher program.

Strategy 2, Activity 4.A
Housing Health Outreach Team

Objective: Help formerly homeless people to retain housing.

Activity 2.4.A: Improve the ability of formerly homeless people to retain permanent housing by providing comprehensive on-site services and connection to community resources through a Housing Health Outreach Team (HHOT) in permanent supportive housing sites.

Agencies funded: Neighborcare Health and HealthPoint

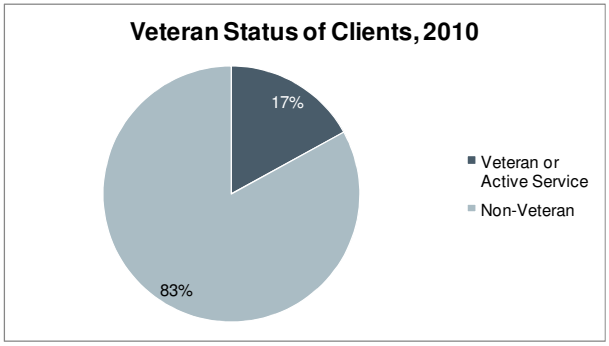
Services start date: May 2007 in Seattle and June 2008 in South King County

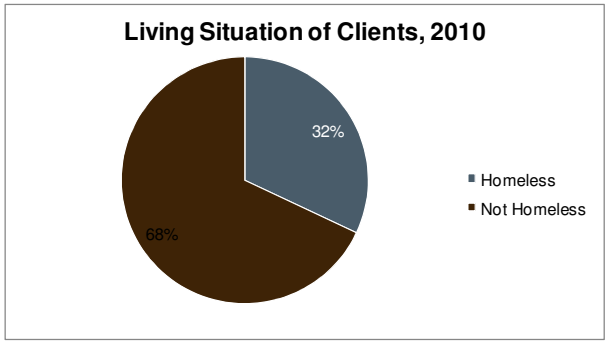
Performance 5/2007 – 12/2010

- A total of 2,525 individuals have been served.
- A total of 746 persons were linked to community-based primary health care services.
- A total of 888 clients with mental health and/or substance abuse conditions engaged in services.
- A total of 1189 clients with chronic health conditions set a self-management goal.

Services provided

The HHOT provides health care linkages and support to homeless and formerly homeless clients living in Seattle and South King County. The team of medical, mental health, and chemical dependency providers helped clients establish a regular health care regimen, rather than relying on costly emergency care.





Most recent measured outcomes – 2010

Of the 655 housing clients, 461 clients were eligible to be measured for a full year's housing tenancy. Of the 461 clients measured, 84 percent (386 clients) remained in housing for the full year and were housed at year-end. Those not eligible for measurement included: 157 clients who moved in during 2010, 18 clients who died, and 19 clients for whom staff was unable to attain tenancy information.

Ninety-three percent of clients have either maintained housing for at least one year, or transitioned to supportive services, treatment, or jail. Of the 75 clients who left housing in 2010, 43 clients moved to other housing, skilled nursing facilities, treatment facilities, jail, or in with family or friends. The remaining 32 people (7% of the total) returned to homelessness or a destination unknown.

Client story: Matthew was actively drinking when he connected with the HHOT team in the building where he lives. He agreed to start an antipsychotic for his bipolar disorder and very disordered sleep schedule, which was prescribed by the HHOT physician. Matthew stabilized enough on medication to seek out mental health care and an enhanced medication plan, and connect with his primary care provider. With his sobriety and mental stability, he has reached out to others in the building, advising those who are using and bringing neighbors to the food bank. He attends AA meetings regularly. He was over 100 days sober at year-end.

Evaluation questions

How was the program expanded or enhanced with levy funding?

Levy funding allowed Neighborcare Health to add a behavioral health practitioner to the HHOT in downtown Seattle. In addition, it created a partnership between Sound Mental Health and HealthPoint to add a nurse to the team that serves formerly homeless individuals in South King County. The team expanded to 6.0 FTE nurses and a 0.3 FTE physician by the end of 2010 and expanded to two new sites.

Who has been served through this program?

This program prioritizes single adults in Seattle and South King County who were previously homeless. Clients typically have mental health and substance abuse conditions, including PTSD. Because the HHOT program serves people who have been placed in a permanent supportive housing unit, most of those served by the program were not homeless when receiving HHOT services, but all had been homeless or at risk of homelessness in the past. Approximately 15 percent of those served by the program were veterans or active service members. Most recent demographic data show:

- About two-thirds of HHOT's clients were seen in Seattle (67%) and the rest in South King County.
- Most of those served ranged from 35 to 54 years old.
- Over one-third of people served by HHOT were women.
- Just over 60 percent of those served are white and about seven percent of those served were Hispanic or Latino.

Lessons learned

- In 2009, the downtown HHOT began foot care clinics at several housing sites, which were very effective in increasing referrals to behavioral health and chemical dependency services.
- The HHOT team has designated certified staff as specialists on the team in the areas of wound care, immunizations, and foot care, and will have a diabetes-certified specialist on the team by the end of 2011. They piloted a Hepatitis immunization project in 2010.
- Strong communication within interdisciplinary teams is important, especially when providers are from different agencies. Two teams coordinate closely with housing support staff to connect residents with primary care, mental health and chemical dependency services in the community.

Are any changes in the program model anticipated?

No changes are anticipated.

Strategy 2, Activity 4.B
Invest in supportive services and operating costs for existing and new permanent housing

Objective: End homelessness for vulnerable at-risk individuals and families by providing resources that improve their ability to secure and maintain permanent housing.

Activity 2.4.B: Improve the ability of formerly homeless people to retain permanent housing by providing comprehensive on-site services and connections to community resources. This activity provides funds for support services and operating costs for limited housing for formerly homeless households.

Agencies funded: Evergreen Treatment Services, Valley Cities Counseling and Consultation, Downtown Emergency Service Center, Low Income Housing Institute, Sound Mental Health (McDermott Place), Eastside Interfaith Social Concerns Council, Plymouth Housing Group, Compass Center, Archdiocesan Housing Authority, St. Andrew's Housing Group

Services start date: January 2008 (earliest, varies by contract)

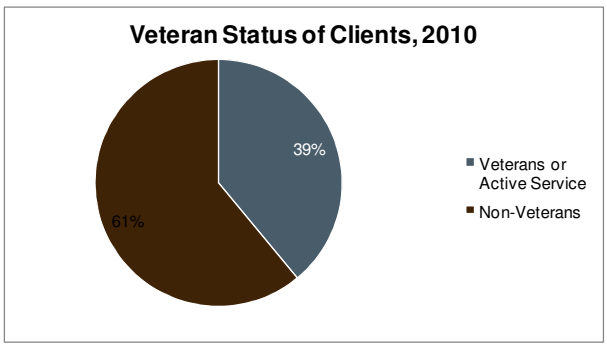
Performance 1/2008 – 12/2010

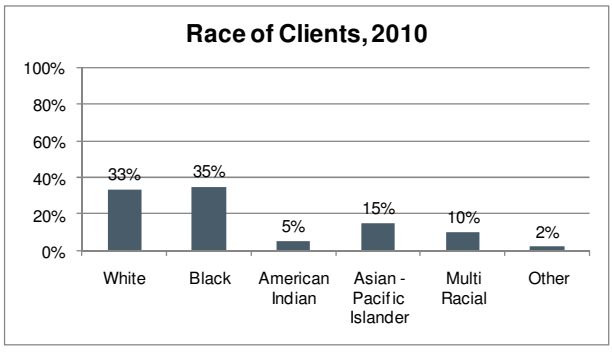
- A total of 782 individuals in 722 households have been served.
- A total of 100 percent of those served were homeless when they were first identified for services.
- Approximately 24 percent of those served by the program were veterans or their spouses or dependents.

Services provided

Levy funds have been awarded to non-profit organizations that have identified units of permanent housing and have a solid, on-site service plan to meet tenants' individual needs.

Supportive services may include case management and advocacy, engagement and outreach, housing support and life skills training, employment counseling, job search assistance, education and training, money management and credit repair, domestic violence and sexual assault support, mental health and substance abuse counseling, legal assistance, children's services, and interpreter services. The program serves veterans and their families in need, homeless and chronically homeless individuals, individuals who have recently been released from jail who are striving to maintain or re-unite with their family and families and children who are homeless or at risk of homelessness with involvement with justice, child welfare and other systems.





Most recent measured outcomes – 2010

Ninety-two percent of households served increased their housing stability, measured by the percentage of clients who maintain housing for at least one year.

Client story: In June 2008, the Homeless Service Enhancement Program (operated by Valley Cities Counseling and Consultation) received a client referral from the King County Veterans' Program. The head of household is a female veteran who suffers from post traumatic stress disorder, and is coping with chemical dependency issues. The client was homeless and in need of permanent and stable housing at the time of the referral. The veteran head of household is a mother of two and at the time of the referral, the children were living with a family member out of state, and allegedly being abused by another family member. In August 2008, the client traveled out of state to retrieve her children from this situation. During this time, the Homeless Service Enhancement Program was able to apply for and obtain an apartment, so it was ready for this family upon return. The family was housed in August 2008, and has been living in this apartment ever since. The mother has full-time employment, has accessed and is using Valley Cities mental health services for her and her children, and the children are attending school regularly. This client is now able to work regularly and is feeling much more confident about the future for herself and her family. This client continues to maintain her housing and job, and she has been successful in obtaining other resources that she needs. Over the last two years, the Valley Cities staff has watched her achieve numerous goals and grow more self sufficient, which means that she is now requiring fewer case management services from the program, which in turn creates service availability for other clients in need.

Evaluation questions

How was the program expanded or enhanced with levy funding?

Levy dollars were used to fund the operating and services component of creating new units to serve very high-needs households, many of whom are veterans and/or have been homeless long-term. McDermott Place is an example of how levy funding was critical to expanding housing and services for veterans: levy dollars completed the funding portfolio, helping the project overcome multiple funding gaps for capital, operating, and services. The funding structure has encouraged effective partnerships, allowing agencies to form collaborations that allow them to work together to meet the needs of homeless veterans.

Who has been served through this program?

Providers served 505 clients in 2010. Most were adults, but 27 percent of those served were children under 18 years old.

- All of those served were homeless when they were first identified for services.
- Fifty-seven percent of those served were men.
- Approximately 38 percent of those served were white; approximately 40 percent of those served were African American.
- Approximately 24 percent of those served by the program were veterans, spouses, or dependents of veterans.

Lessons learned

- Funding for services and operations paired with 50-year capital commitments has resulted in a new capacity to serve the most vulnerable, highest needs populations. Longer-term funding (five years) for services and operating costs was key to securing capital commitments for these units.

- Funding services adequately in both quantity and duration to meet this population's needs has effectively eliminated the need for screening barriers for this population, allowing those who most need housing and services to come in first.
- Overall, the 2010 housing stability rate for these programs is 92 percent, which is impressive given the severe needs of some of these clients, and the numerous barriers many of them face as they work to maintain permanent housing.

Are any changes in the program model anticipated?

Services will adjust based on the needs of the population, and may change over time as more is learned about serving this population. Currently this population's need levels are very high, which calls for 24/7 on-site residential and case management services.

Efforts are being made to streamline requirements and reporting for agencies, as some funding sources have different restrictions or additional reporting/evaluation requirements.

Strategy 2, Activity 5.A
Criminal justice initiatives – Forensic program for Homeless Individuals with Severe Mental Illness who Come in Contact with the Legal System

Objective: End homelessness and provide high intensity wraparound services for vulnerable individuals who have cycled through local jails, by providing resources that improve their ability to secure and maintain permanent housing.

Activity 2.5.A: Provide supportive housing options and intensive services to homeless individuals who are mentally ill or have co-occurring substance abuse disorders as they reenter the community.

Agencies funded: MHCADSD – Forensic Assertive Community Treatment (FACT); Sound Mental Health

Services start date: January 2008

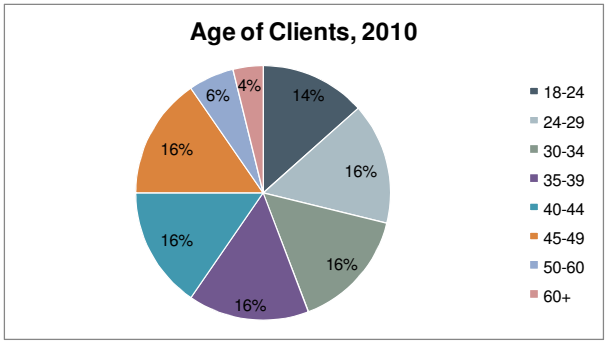
Performance 1/2008 – 12/2010

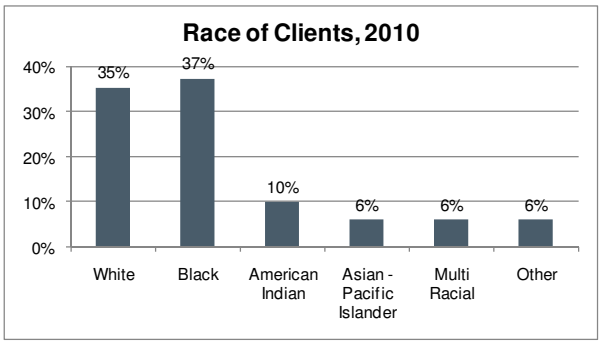
- The FACT program has served 132 individuals.
- Fifty-one clients have been engaged in services.
- Forty-five clients moved into housing.

Services provided

The FACT program will provide services over a five-year period for 50 individuals who have a history of homelessness and suffer from severe and persistent mental illness. The program serves the most frequent institutional users of King County jails and municipal jails. The FACT model is a participant-centered, recovery-oriented intensive service delivery model. It uses a transdisciplinary team of a spectrum of service provider staff to provide comprehensive, community-based holistic treatment, rehabilitation, and support.

The FACT participants are offered housed and provided with ongoing assertive outreach in the community and ongoing engagement to promote recovery and reduce criminal justice involvement.





Most recent measured outcomes – 2010

Housing retention was measured for the 49 participants who had been enrolled in the program for at least six months and had been placed in housing at some point. Thirty-eight participants (77.6%) had retained housing for at least six months.

During 2010, 42 participants were housed at some point during 2010. As of December 31, 2010, four participants were in independent permanent housing, 21 participants were in permanent supportive housing, five were in temporary housing, and three participants resided with family. For the 14 participants not in housing, one was in a psychiatric hospital, two were in jail, one was in immigration detention, one in residential chemical dependency treatment, and nine were homeless.

Employment: No FACT participants were employed at enrollment. By the end of 2010, three participants were employed part-time and one had returned to school part-time.

Participant story: Mr. W is a 45 year-old African American male and has been enrolled in the FACT program since April 2008. He was living on the streets at the time of enrollment and had several assaults, robbery, trespass, and drug related charges. Mr. W is diagnosed with schizophrenia paranoid type and alcohol, cocaine and nicotine dependence. Prior to enrollment in the FACT program, he was not receiving any medications for his mental health issues, using crack cocaine on a daily basis and drinking frequently and heavily as well as smoking heavily. Mr. W was responding to internal auditory hallucinations that constantly told him he would die and that people were after him. Upon enrollment in the FACT program, Mr. W continued to use substances for about six months, consistently putting his housing and personal safety in jeopardy, and ended up being evicted from housing due to assaulting someone.

He failed at another housing placement due to drug use and later moved into McDermott House in Lake City. Mr. W was happy to move out of the downtown area and felt it would help him to decrease his drinking and drug use. More importantly, he made a decision to become more actively engaged in treatment. Mr. W made sure to stay medication compliant and regularly see his provider. He began to go to more FACT groups such as Moral Reconation Therapy and the Balanced Living. He joined The Emerald House, a mental health clubhouse provided by Sound Mental Health, and became more socially active in a positive way. He has also participated in several sober support outings. He now realizes the negative effect that drug and alcohol use has had on his home life and his overall health, and is making a consistent effort to decrease his use and fill his time with positive and healthy activities.

Mr. W's primary goal is being sober from drugs and alcohol and staying medication compliant. He has recently started dating a female friend and has been going on sober support outings with her and through the FACT program. Mr. W acquired a temporary job as a roofer over the summer. He spent some of his earnings on new clothes and positive social outings, rather than drugs and alcohol as in the past.

Mr. W has decreased his drug use to once every two to three weeks, reduced his drinking to about two 8-ounce beers per week, and decreased his smoking to six cigarettes per day. Meanwhile, he has not been arrested and has remained medication compliant for over a year. Mr. W has plans to get another part time job soon and possibly go back to school in the future. With focused individual therapy, case management, social support, and several group therapies, the participant has realized the benefits sobriety has to offer him and is working hard to continue taking meaningful positive steps in his recovery.

Evaluation questions

How was the program expanded or enhanced with levy funding?

The FACT program has multiple fund sources, of which the Levy represents approximately 30 percent of the 2011 program cost of $708,000. All existing fund sources for the FACT program sunset on December 31, 2011.

Who has been served through this program?

The FACT program began in 2009 with 30 clients enrolled and 13 engaged. By November 2009, FACT had reached program capacity at 50 clients.

During 2010, FACT served 51 participants.

- At the time of enrollment in FACT, none of the 51 participants had permanent housing: 18 were homeless, 20 were incarcerated, four were hospitalized, and nine were in temporary housing.
- Most participants were between 18 and 49 years old, with five over the age of 50.
- Over 75 percent of those served were men and two-thirds were persons of color.
- Four veterans were served by the program (8%).

Lessons learned

- Locating eligible participants was particularly challenging, since the target population is very transient.
- Initially, the program struggled to enroll eligible individuals who were also veterans due to other eligibility criteria, but were able to enroll the minimum by the time the program reached capacity.
- Those identified were the highest utilizers of King County jails who also met the eligibility criteria for the Assertive Community Treatment (ACT) model that FACT is based upon, with a diagnosis of a severe and persistent mental illness. Most of the participants were first contacted by the FACT team while incarcerated within King County, and the team began the intake assessment and assertive engagement process for many participants while they were still in custody. The FACT team has worked closely with the courts (many jurisdictions throughout King County), Jail staff, Jail Health Services staff, and probation and community corrections staff to effectively coordinate the court processes, mental health court referrals, and expedited release from jail.
- In the initial years, there was reluctance to graduate participants from the program to less intensive services. Some participants should have been exited sooner.

Are any changes in the program model anticipated?

King County is exploring graduation options for this population to ensure some program capacity for new referrals.

Strategy 2, Activity 5.B
Program for Homeless Individuals and Veterans with Mental Illness who come in Contact with the Legal System and have Histories of long-term Homelessness

Objective: End homelessness for vulnerable at-risk individuals by providing resources that improve their ability to secure and maintain permanent housing.

Activity 2.5.B: Provide permanent, supportive housing options and intensive wraparound, time unlimited services to homeless offenders who are mentally ill or have co-occurring disorders and cannot participate in Mental Health court due to lack of competency and/or are eligible veterans.

Agencies funded: Sound Mental Health; MHCADSD–Forensic Intensive Supportive Housing (FISH)

Services start date: April 2009

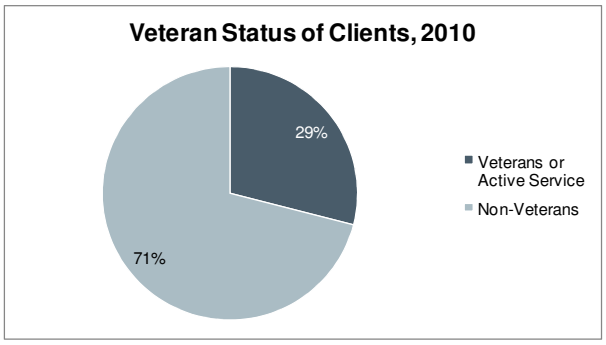
Performance 4/2009 – 12/2010

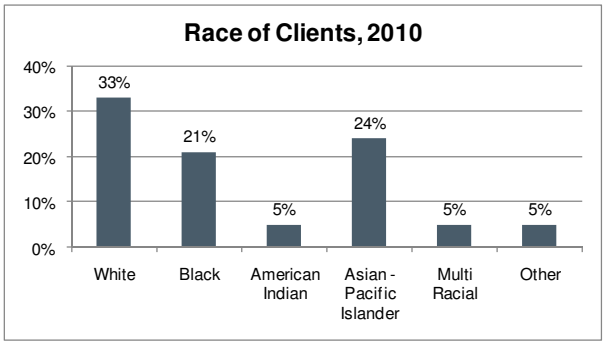
- The FISH staff screened and assessed 218 court involved homeless persons.
- Of the 218 persons assessed, 63 were determined to be appropriate for the FISH project and were enrolled.
- By the end of 2010, the program had reached capacity at 60 clients: 87 percent were male, 38 percent were veterans.

Services provided

The FISH aims to end homelessness for individuals who cannot opt into a Mental Health Court in King County because their charges are dismissed due to not being legally competent to stand trial. This group represents a population of frequent institutional users of both psychiatric hospitals and local jails.

The FISH provides permanent, supportive housing and services over a five-year period for up to 60 individuals annually that have been homeless and have mental illness and/or substance abuse issues and significant service support needs. The FISH team is mobile and delivers services in community locations rather than expecting the client to come to the clinic or program site.





Most recent measured outcomes – 2010

The measured outcomes include the number of clients who move into housing and then retain it for at least six months. For those clients who had entered housing and been housed for at least 6 months, 81 percent (42 of 52 clients eligible for measurement) remained in supportive housing for at least six months.

A total of 58 clients resided in permanent supportive housing at some point in 2010. At the end of the year, 45 clients were in permanent supported housing, five were in temporary or respite housing, and 10 were not being housed by the program. Of the 10 not in housing, three were being treated in a psychiatric hospital, four were in jail and three were homeless. Of the three homeless clients, two had refused housing and one had left housing.

Jail bookings and days: For the 41 clients who have been in the program for at least one year by December 31, 2010, at least half of the clients (23 clients, 56%) reduced their number of bookings in the year following enrollment. Jail days in the year prior to enrollment totaled 2,655 and declined to 2,176 in the year post-enrollment. There were 177 bookings in the year prior to enrollment, declining to 85 in the year following enrollment.

Sobering episodes for clients who have been with the program for one year have been significantly reduced from 267 sobering episodes in the year prior to enrollment to 17 episodes, a 94 percent decline.

Outcomes	One Year Pre-Enrollment	One Year Post-Enrollment	Percent Decline
Jail Bookings	177	85	51.9%
Jail Days	2655	2176	18.0%
Sobering Episodes	267	17	93.6%

Client story: Mr. M is a 59 year-old Caucasian male with a history of depressive disorder not otherwise specified (NOS), psychotic disorder NOS, opioid dependence, and traumatic brain injury resulting in a seizure disorder and the loss of one eye. He also has significant short-term memory impairment and has limited use of his hands due to nerve damage, severe arthritis, and several amputated fingers. Mr. M spent the majority of his adulthood fishing in Alaska where he worked in many capacities including captaining his own vessel in the Bering Sea. He has a history of episodes of homelessness since 1998 and an extensive criminal history including assault and trespassing, and multiple drug convictions.

Mr. M came to the FISH program in April 2009. He was placed in supported housing and began working regularly with his case manager to set goals for his future. He is a regular heroin user and has continued to use since enrolling in the program. However, he has begun to reduce his use and has learned to access clean needles. Further, he is now beginning to express interest in opiate substitution treatment (methadone) and is becoming more comfortable talking openly with staff about his addiction.

When Mr. M. began the program, he rarely sought medical attention and held very negative beliefs about doctors and the medical community; when he did seek medical attention it was to a hospital emergency room (ER). While he continues to us local ERs, he has begun to accept medical treatment through outpatient services at local clinics and is learning to trust doctors again. Working with Mr. M to adhere to medication regimens remains a work in progress; however, he has begun to recognize that medications are helpful in managing his symptoms and is beginning to show more motivation to engage in mental health treatment.

Without the FISH program it is likely that Mr. M would still be homeless, without benefits, utilizing local ER's, and frequenting the King County Jail. Instead, he has become part of the therapeutic community, has a regular and positive routine, is learning to take better care of himself, and is making better choices. He is learning that, with support, he can still experience a fulfilling life. Now, instead of street drugs, Mr. M is now often seen drinking his cup of "joe" in the window at a local coffee shop near his apartment.

Evaluation questions

How was the program expanded or enhanced with levy funding?

The FISH team model was initially entirely funded by levy funds. The levy pays for the transdisciplinary team of professionals who work to provide outreach, treatment, psychiatric rehabilitation, housing and reentry support services.

Who has been served through this program?

In 2010, FISH engaged and screened 88 individuals with a history of homelessness who had been involved in mental health court competency reviews: 22 were appropriate for FISH and enrolled in the program.

- All clients were homeless at the time of enrollment.
- Most range in age from 35 to 59. Four individuals are age 60 and above.
- Most clients (87%) are men and two-thirds are persons of color.
- Twenty-three veterans (38.3 percent of clients) enrolled in the program during 2010.

How effective have services been?

The FISH program is an intensive and supportive Housing First project that is tailored to provide effective prevention and intervention strategies for those most at risk and most in need to reduce or prevent more acute illness, high-risk behaviors, incarceration, and other emergency medical or crisis responses.

Lessons learned

- The major revelation reported was around how to engage clients in services. The "Housing First" approach is based on the premise that individuals want housing. However, housing was not always a prime driver: in some cases, the motivator was access to services rather than housing.
- The boundary spanner function is essential, especially when navigating a difficult process where legal competency is juxtaposed up against the civil commitment process. The boundary spanner is able to work with providers, King County Crisis and Commitment Services, and the courts, and has become comfortable navigating and working closely with all systems.
- Availability of housing stock is fluid and program staff must continually monitor housing to ensure that the environment continues to be safe and supportive for these clients. Program staff must continually build housing resources to ensure a sufficient and appropriate variety of housing options.
- Mental health issues alone do not characterize the FISH participant population. Drug use is a significant challenge and most clients are diagnosed with co-occurring disorders (mental health and chemical dependency) and many have significant health issues requiring primary medical care.
- Graduation housing options are needed. Currently, housing options in King County are extremely limited for this population's income level and barriers.

Are any changes in the program model anticipated?

The addition of nursing staff dedicated to the program is needed if funding allows.

Strategy 2, Activity 6
Permanent Housing Placement for Criminal Justice involved Parents (Combined with activities 4.4 and 4.6)

Objective: End homelessness for vulnerable families by providing resources that improve their ability to secure and maintain permanent housing, as well as by promoting family stability and effective child development.

Activities 2.6, 4.4 and 4.6: Overcome barriers to securing and maintaining permanent housing for single parents with young children who have criminal justice system histories and who are exiting jail or transitional housing.

Agencies funded: First Place – Family Reunification Project; YWCA

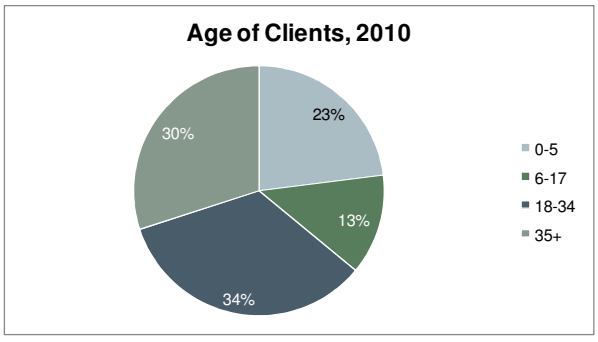
Services start date: September 2008

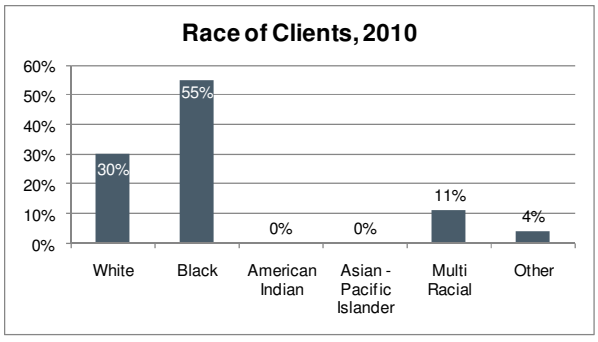
Performance 9/2008 – 12/2010

- A total of 93 households (160 individuals) have been served.
- A total of 57 percent of the households increased housing stability or reunited with their children.
- A total of 7,273 hours of case management have been provided.

Services provided

This program identifies single parents with recent criminal justice involvement who have potential and interest in reuniting with their children. This activity is linked with Activities 4.4 and 4.5. Services are flexible and customized to meet the specific needs of adult and child household members. This activity funds permanent housing placement supports, such as assistance in identifying permanent housing, as well as case management support for up to one year as needed for households to maintain their stability in housing. Levy funds do not cover services to children, so agencies are required to provide needed children's services with other funding sources.





Most recent measured outcomes – 2010

Measured outcomes include clients reuniting with their children, establishing housing stability, and reducing criminal involvement and recidivism. Fifteen clients from First Place and eight clients from the YWCA successfully reunited with their children and moved to permanent housing.

Client story: Silvia first heard about First Place while riding the bus and talking to another First Place client. She and her daughter, who was five years old at the time, were couch surfing, and although First Place did not have a housing unit available for eight months, Silvia's daughter was able to enroll in the First Place Kindergarten, and Silvia began volunteering there. Silvia spoke limited English, and was self-taught.

First Place assigned Silvia a case manager. She disclosed she had some pending warrants, and was afraid to follow up on them and risk losing custody of her child. First Place staff helped Silvia work with court officials to have her cases dismissed. During counseling sessions, Silvia expressed a desire to become a chef. First Place helped her enroll in Fare Start's 16-week program, and has since graduated in the top two of her class. She recently interviewed for a cook position in a Bellevue nursing home. In addition, has begun the process to enroll at Seattle Central Community College in the Culinary Program. Her daughter successfully completed Kindergarten and 1st grade, and has improved academically, socially, and emotionally, thanks to stable housing.

Evaluation questions

How was the program expanded or enhanced with levy funding?

The levy funded this program, through which families have received case management with the goal of clients reuniting with their children, establishing housing stability, and reducing criminal involvement and recidivism. Over 1,500 hours of in-reach were provided, including workshops at state correctional facilities and local jails, and contacts with potential clients who learned about the program through other means.

Who has been served through this program?

During 2010, the YWCA served 31 families and First Place served 25 families.

- All household members served were homeless.
- The adults in the program ranged from 18 to 59 years old; 47 percent of the children served were under the age of five.
- Most clients (69%) were female.

Lessons learned

- Experience to date with this activity has confirmed that this is a particularly difficult population to work with, even when compared with other high-needs families. These families often have intergenerational criminal justice system involvement, many have never worked legally, and many families are unaware of the legal status of their children.
- These are complex situations and require significant assistance, with intensive and long-term supports. Progress comes in slow, incremental steps, but families are making strides toward stability.

Are any changes in the program model anticipated?

The Passage Point facility opens and lease up will begin in July 2011. The transition to facility-based services will allow them to deliver more intensive services to more clients (up to 47 households) and the scattered site model will be phased out.

Strategy 2, Activity 7
Housing Stability Program

Objective: End homelessness for vulnerable at-risk individuals and families by providing resources that improve their ability to secure and maintain permanent housing.

Activity 2.7: Expand a countywide Housing Stability Program (HSP) for veterans and other persons to help stabilize them in their homes and prevent homelessness.

Agencies funded: Solid Ground (lead agency), which partners with Hopelink, Catholic Community Services, Friends of Youth, YWCA – SeaTac, Valley Cities, Multi-Service Center, Senior Services, Vashon Youth and Family Services, First Place, Neighborhood House, Salvation Army – Seattle, YWCA – Seattle, Crisis Clinic/Community Info Line.

Services start date: May 2008

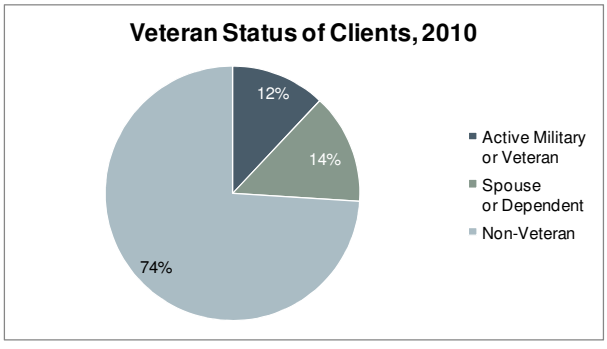
Performance 5/2008 – 12/2010

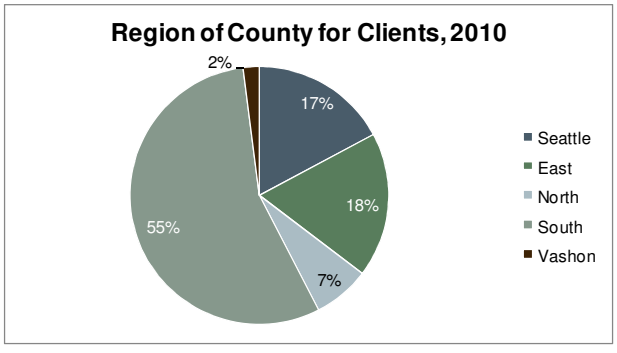
- A total of 1,822 households (5,009 individuals) have been served.
- Ninety-three percent of households have maintained their housing at 12 months post-assistance.
- In 2009, a study showed that the average rental assistance was $1,360 and average mortgage assistance was $2,500 per household.

Services provided

The HSP provides emergency financial assistance for low-income renters and homeowners (under 80 percent of area median income) in response to short-term crises that prevent them from making timely payment of their rent or mortgage. The HSP serves households who are at risk of losing their housing, or who have their own lease pending but need assistance with move-in costs.

The HSP services are designed to be limited touch and are not set up to provide deeper housing stability issues. Households complete a budget analysis and action plan to determine income and expenses, outline goals, and identify resources and potential budget savings. Clients are referred to money management classes and to other support services they may need.





Most recent measured outcomes – 2010

By the end of 2010, 96 percent of those contacted had retained their housing for at least 6 months following HSP assistance. For those households receiving HSP assistance more than 12 months ago, 93 percent of those contacted had retained their housing for a full 12 months

Client story: Richard is a U.S. military veteran who contacted the Community Information Line (CIL) to get help with his rent. A work-related injury left Richard unable to work, which left the household without its primary source of income, and struggling to make ends meet. While his claim was being processed with the Department of Labor and Industries, Richard's partner, Anna, had her work hours cut, which further reduced their already diminished income and created additional household instability. The Housing Stability Project (HSP) provided rental assistance to enable them to get current on their housing costs and get them through the temporary emergency. At around the same time, Richard found out that his employer was going to be transferring him to a different location where could work without the risk of injury. The financial assistance provided by HSP made it possible for the Richard and Anna to maintain their housing and regain a stable footing going forward.

Evaluation questions

How was the program expanded or enhanced with levy funding?

In 2009, the HSP expanded almost three-fold and was able to place new emphasis on targeting veterans. In 200, the HSP continued to emphasize targeting veterans by working closely with the VA and King County Veterans Program and reaching out to other veterans' organizations.

Who has been served through this program?

The HSP serves households at risk of losing their housing throughout the county with levy funds.

- Nearly 15 percent of those served did not have their own housing at the time they requested assistance, and the remainder were at risk of losing their housing.
- Those served included families with children, with family members ranging in age from birth to 85.
- About one third of households are headed by a single female parent (31%).
- Access for veterans and the capacity to serve them has been much improved, and 31 percent of all households served in 2010 were veteran households.

Lessons learned

- To ensure improved access for veterans, it was necessary to implement a direct referral mechanism, whereby KCVP staff members are able to schedule eligible veterans with an appointment at an HSP partner agency.
- The average amount of rental assistance needed per household stabilized in 2010. Agencies had seen increases in the amounts of rental assistance needed across 2008 and 2009, which affected the number of households HSP was able to serve.
- There is a continuing strong need for services in South King County. While these services are needed around the county, the need in South King County continues to outpace other regions of the county.
- The most common contributing factors to the need for assistance were (1) job loss or cut in hours (27%); illness (16%); domestic violence or family break-up (13%) and needing help with move-in costs after homelessness (10%). All households reported at least two contributing factors, and about one-third cited three or more factors contributing to their housing crisis.

Are any changes in the program model anticipated?

None at this time.

Strategy 2, Activity 8.A
Link educational, vocational and employment to housing and supportive services

Objective: Improve the housing stability of at-risk and formerly homeless individuals by overcoming health and related barriers to securing and retaining employment.

Activity 2.8.A*:* Expand existing education, employment, and vocational training programs for the homeless or formerly homeless; expand child care services that enable parents to work; provide dental care vouchers for those whose oral health poses a barrier to finding or maintaining employment.

Services start date: August 2008

Agencies funded: Friends of Youth, Hopelink, Neighborhood House, Pioneer Human Services, TRAC Associates, WDVA, YouthCare, YWCA, Valley Cities Counseling and Consultation.

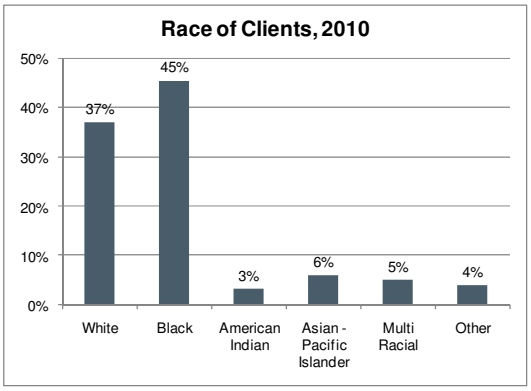
Performance 8/2008 – 12/2010

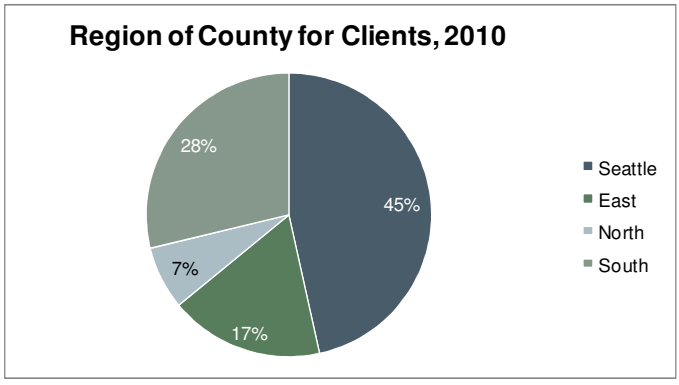
- A total of 1,937 individuals have been served.
- Most recent outcome data shows that 61 percent have retained the jobs acquired and increased their income.

Services provided

Levy funds have enhanced existing programs that provide employment and housing services to homeless or at-risk individuals and veterans (at or below 175 percent federal poverty level) who are experiencing multiple barriers to stable employment and housing.

Nine projects were funded based upon a RFP process conducted in 2008. Each project focuses on different high need populations such as youth, justice involved individuals, refugees, veterans etc. All projects use employment-focused case management services customized to client needs and goals. Services include assessment of client's employment, housing, and other needs; preparation for work, training or other work-related opportunities; job readiness, search, and placement assistance; referrals for additional services; assistance obtaining needed work supports; client benefits planning; and retention services to assist clients in maintaining stable employment and housing.





Most recent measured outcomes – 2010:

- During 2010, 947 clients were enrolled in nine programs.
- A total of 414 individuals were placed in a job or a training program.
- A combined 61 percent of individuals placed in jobs or training met their goals for increased income and retention of employment - ranging from 34 percent to 97 percent depending upon the project.

Client story

In December of 2010, Wendy successfully completed 12 months of positive job retention. When she started at Pioneer Human Services (PHS), her housing was temporary and unstable, and her car needed repair to be able to make it to work each day. After providing Wendy with support services funds to repair her car and get other needed work supports, she focused on getting more stable housing. After two months at PHS, Wendy had saved enough for her first and last month's rent, and deposit, and moved into her own apartment. Over the past year, she has also been clean and sober, and regained custody of her two sons. Although she felt going back to school was out of reach, she will soon start classes at a community college to pursue a drug and alcohol counseling certification, which PHS will cover if she is not able to qualify for financial aid.

Evaluation questions

How was the program expanded or enhanced with levy funding?

Levy funds have been awarded to enhance existing programs that provide employment and housing services in King County. Levy funding has provided funding flexibility depending upon the program. This has enabled programs to serve populations more effectively by paying for individualized supportive services based upon client need, with the funds used for any services that support meeting goals for employment.

Who has been served through this program?

This activity serves very low-income individuals and veterans (at or below 175 percent federal poverty level), including those who are homeless or formerly homeless, and are experiencing multiple barriers to stable employment and housing. Most recent demographic data (2010) show:

- A total of 223 clients were veterans (24 percent of all clients) – most of who received services from three programs that specifically targeted veterans.
- Close to half of all clients (45 percent) were seen in Seattle and 26 percent were seen in South King County offices.
- Close to two-thirds (63 percent) of those enrolled during 2010 were homeless, with significant barriers to employment.
- All of those served were adults, ranging in age from 18 to 74.
- Over half (56 percent) of those served were men.

Lessons learned

- Finding job and training opportunities in the current economy is a significant challenge for clients, and is compounded by significant client barriers, including limited work history and job skills.
- Given the wide range of populations and program configuration, it demonstrates the need customized approaches to employment projects that can become skillful in overcoming particular populations'

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barriers. This creates a challenge to summarize the overall Levy program success – requiring individual project level review, analysis and understanding.

- In spite the wide range of project-level successes, the overall success rate is strong, as it takes time to work though barriers and stabilize these clients. Getting and keeping living wage jobs is very difficult, as is overcoming instability.
- Some projects have been more skillful at creating effective partnerships with mainstream employment services and implementing employment and education best practice models. These projects have outperformed those that services are more isolated and independent from mainstream services.
- Flexible funding is important. Agencies can structure supportive services to fund what their clients need, and the funds can be used for any services that support employment. Structuring this funding to be flexible and making it part of the contract is helpful for King County and agencies alike.
- Employment-focused case management is definitely needed. Direct services in this area make a difference. Strong links to wrap-around services are critically important, especially housing, since housing stability is key to maintaining employment.

Are any changes in the program model anticipated?

Future RFP's will emphasize stronger connections with mainstream employment service providers and implementing established best practices.

Strategy 2, Activity 8.B
Link educational, vocational and employment to housing and supportive services

Objective: Improve the housing stability of at-risk and formerly homeless individuals by overcoming health and related barriers to securing and retaining employment.

Activity 2.8.B*:* Expand existing education, employment, and vocational training programs for the homeless or formerly homeless; expand child care services that enable parents to work; provide dental care vouchers for those whose oral health poses a barrier to finding or maintaining employment.

Services start date: March 2010

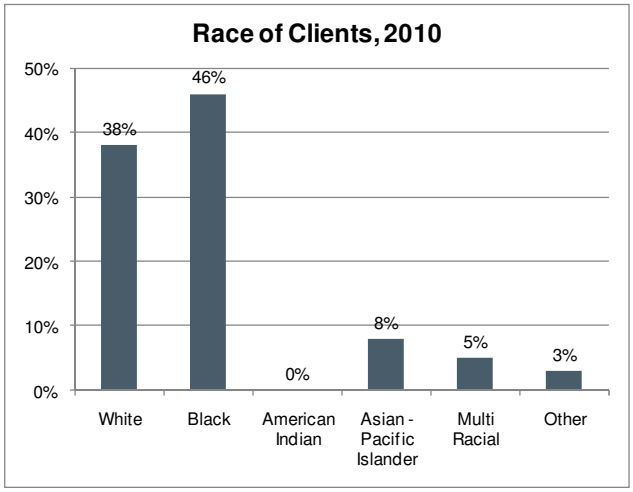
Agencies funded: King County DCHS – Work Training Program, Career Connections

Performance 3/2010 – 12/2010

- A total of 122 individuals were served in 2010.
- Thirty-eight clients entered an educational program to enhance employability, with 11 clients completing vocational certificate programs and 17 enrolling in college. Ninety percent of all clients have established education-related goals, including vocational and post-secondary education.
- Twenty-nine clients obtained new jobs, ranging from $8.55 to $27 per hour and 79 percent (23 clients) retained their jobs through the end of the year.
- Most clients (62 percent) were persons of color and 26 percent of all clients were veterans (32 veterans served).

Services provided

Levy funds have created a new program to provide homeless families and individuals who are receiving short-term rental subsidies with skilled coaching and intensive education and employment services. These services are critical to ensuring that households can raise their incomes sufficiently to support their housing after the subsidy expires, and to move up the career earnings pathway towards self-sufficiency.



Education at Intake	
Less than high school diploma	12%
GED	11%
HS Diploma	26%
Voc Cert	28%
Associates Degree	8%
3yrs college	2%
Bachelor's	10%
MA	1%
PHD	2%

Most recent measured outcomes – 2010:

- One hundred twenty-two clients were enrolled.
- A total of 55 percent increased participation in employment and/or education-related activities.
- A total of 29 individuals were placed in a job and 38 individuals enrolled in college or a vocational certificate program.

Client story

B is a 41-year-old Navy veteran residing in a transitional housing program. At entry, he was unemployed with $200.00/month income in food stamps. The Veteran was seeking employment as well as expressing an interest in furthering his education. As the coaching process proceeded, B shared that his true passion was to work in the maritime industry. The Employment and Education Counselor first helped him with his job search. Within 2 weeks, he started work fulltime at a Bellevue restaurant, earning $10.00 per hour. Although this was not his career job, he excelled and impressed his employer and remained consistently employed.

The EEC and Veteran turned attention to his education goal, finding a Seattle Maritime Academy program administered by Seattle Central Community College. Fully accredited by the U.S. Coast Guard, it is the only program of its kind serving Washington and Alaska. In the process of completing the Federal student aid application, a years-earlier student loan default showed on his record. Additionally, his driver's license was suspended due to back child support arrears. The EEC encouraged B to attend a hiring event for an Alaskan fishing / seafood processing company, and he learned that by working as a cook on the boats for 5 months, he could both earn enough money to pay off the child support and student loan debts, and obtain mariner hours that will work toward his able-bodied seaman certification. The Veteran remains in contact with his EEC and will resume services upon his return to Seattle, when he will re-stabilize his housing and enroll in the Seattle Maritime Academy (SMA) to work toward his maritime career goal.

Evaluation questions

How was the program expanded or enhanced with levy funding?

Levy funds have been awarded to create a new program to provide income-boosting employment and education services in King County. Levy funding has provided funding flexibility, which has enabled the programs to serve populations more effectively by funding a coaching model that uses individualized action planning along with targeted financial assistance to help clients access school and work opportunities.

Who has been served through this program?

This activity serves homeless individuals and families who are experiencing multiple barriers to stable employment and housing. In 2010, 122 individuals from around the county were enrolled in services through this strategy, and 55 percent had increased their participation in employment and education activities.

- A total of 26 percent of all clients were veterans (32 clients).
- A total of 28 percent of clients were seen in Seattle and 60 percent were seen in South King County.
- A total of 100 percent of those enrolled during 2010 were homeless, with significant barriers to employment.
- The majority of households served were families with children (65%). These families are primarily headed by a single parent (85%), with 46 single female parents and 7 single male parents.
- All of those served were adults, and they ranged in age from 18 to 74.

- A total of 62 percent of those served were men.

Lessons learned

- Clients are succeeding, despite the high level of barriers to employment and education. The individualized coaching model is working well for this population.
- Knowledgeable navigators make a difference. Career Connections staff, with over 30 years combined experience help clients access entitlements and opportunities, and find creative ways to overcome barriers.
- Flexible support services funds are critical to success for homeless individuals. Often, procuring identification, needed vision and dental services and reliable transportation makes the difference for clients looking for work.
- Tough economic times make accessing employment more difficult and clients will likely need the longer-term support that Career Connections can provide beyond the 12 to 18 month housing subsidy period.

Are any changes in the program model anticipated?

Not at this time.

Strategy 3 Overview
Increasing access to behavioral health services

Objective: Increase the physical health, mental health status, and emotional stability of vulnerable individuals and family members in King County.

Strategy overview: One of the greatest challenges facing King County is the lack of access to mental health and chemical dependency services, especially for individuals or family members who may not be eligible for long-term care in the public mental health system due to their lack of Medicaid eligibility. Without access to needed services, the risks of criminal justice system involvement, hospitalization, homelessness, and family disintegration are greatly increased.

The goals of Strategy 3 activities are to fill gaps in services and provide a continuum of care for people who have been homeless or are at risk for homelessness. The specific strategies provide services for a range of conditions from minor depression to serious chronic mental illness and/or addiction, and serve both persons who are mobile and comfortable using community health clinic services, as well as those who, for physical or emotional reasons, are best served at home. Increasingly, serving veterans calls for enhanced capability for community providers to assess and serve persons affected by PTSD. Resources have been allocated to accomplish four broad objectives:

- Expand behavioral health services through primary care and other providers
- Invest in training in trauma-sensitive services and PTSD treatment
- Train behavioral health providers to use evidence-based practices for PTSD
- Expand and extend availability of in-home mental health services.

How have levy resources been used to meet these objectives?

All strategies build on programs or models that existed in the community prior to the availability of levy funds. Total expenditures through 2010 were $3,323,582 in Veterans Levy funds and $2,296,099 of Human Services Levy funds. Table 2-5 summarizes how levy resources have been used to support Strategy 3 activities through 2010.

Table 2-5: Strategy 3 Activity Resources Used

Activity		Lead Implementing Agency	Date of First Service	Clients Served through 2010	How were levy resources used?	Expenditures through 2010
3.1.A	Integrate MH/CD into primary care clinics (non-veterans)	PHSKC	July 2008	**14,662**	Added behavioral health staff to 22 primary health care clinics throughout King County	$1,875,000
3.1.B	Integrate MH/CD into primary care clinics (veterans outreach)	PHSKC	May 2008	**1786**	Created special South King County outreach and behavioral health to veterans and screening for PTSD through pilot grants	$2,500,714
3.2/3.3	Training programs in trauma sensitive & PTSD treatment	WDVA	July 2009	**2076**	WDVA has expanded and refined PTSD curriculum, paid to organize and conduct trainings	$600,000
3.4	In-home services to treat depression in elderly veterans, others	CSD-HSD	June 2008	**285**	Levy enabled expansion of the program to serve communities of color. Provides contracted services for in-home mental health treatment	$643,967
Total Strategy 3 Clients				**18,809**	**Total $ Strategy 3**	**$5,619.681**

How has levy funding increased access to behavioral health services?

Each Strategy 3 activity that has been implemented by 2010 has an evaluation that is presented in detail in Section 3. These evaluations are specifically focused on results achieved through 2010. Levy funds have significantly expanded behavioral health services to vulnerable populations, active military personnel, veterans, and their families. While each activity's accomplishments are summarized in this report, some overall statistics offer insight into the levy's broad impact. Over $5,619,681 has been expended for additional behavioral health services for 18,809 persons through 2010. Levy-funded activities have met the following results and intermediate outcomes:

Expand behavioral health services through primary care and other providers

- A total of 16,037 persons have received behavioral health assessment and/or treatment services integrated into primary care settings, of whom over 9,762 were indicated to have depression or anxiety symptoms and receiving treatment. Close to 45 percent of 2010 primary care clients who completed enough treatment to be reassessed, successfully reduced their depression or anxiety symptoms, improving their long-term health prospects. This was an increase of 7 percent over clients assessed in 2009.
- A total of 1,130 veterans or their dependants have received behavioral health care integrated into primary care settings, demonstrating a 40 percent success rate in reducing depression, PTSD and anxiety.

Invest in training in trauma-sensitive services and PTSD treatment

A total of 2076 treatment professionals, community service workers, and volunteers have been trained in PTSD symptoms and treatment, expanding the regional ability to respond and support King County veterans experiencing PTSD. Follow-up will determine the extent to which the training has improved their ability to recognize and treat veterans' PTSD.

Expand and extend availability of in-home mental health services

A total of 197 persons have been served with in-home depression treatment. The approach has resulted in a 98.5 percent success rate for reducing depression among the program's clients.

Table 2-6 presents a summary of the 2008-2010 Strategy 3 achievements for each separate activity.

Table 2-6: Strategy 3 Activity 2008-2010 Performance

Activity		Clients Served in 2009	Services		Outcomes	
			Types	Quantity	Outcome Measures	Results
3.1.A	Integrate mental health/chemical dependency into primary care clinics (non-veterans)	**14,671**	Clients assessed Enrolled in treatment	14,462 8,632	Reduced depression or anxiety scale	45 percent
3.1.B	Integrate mental health/chemical dependency into primary care clinics (veterans outreach)	**1786**	Assessed for PTSD/MH Enrolled in treatment Outreach CM and Referrals	1575 1130 596	Reduced depression or anxiety scale	40 percent
3.2/3.3	Training programs in trauma sensitive and PTSD treatment	**2076**	Treatment professionals educated	2076	Clients referred/ Improved treatment	Too early to measure
3.4	In-home services to treat depression in elderly veterans, others	**285**	Recruited Clients enrolled	285 169	Reduced depression scale	96 percent

What lessons have been learned?

Each unique activity funded by the levy has helped us learn very specific lessons related to its implementation. These are reported in the individual activity evaluations in Section 3. However, there are some broadly applicable lessons for all activities to increase access to behavioral health. These offer useful guidance as program adjustments are made over the next two years and considerations on levy funding renewal begin.

- Increasing access to behavioral health care by integrating services into primary care has been successful and has increased our understanding of the extent of need among vulnerable King County populations.
- During implementation, health centers encountered challenges in identifying veterans eligible for services funded by Strategy 3.1. Clinics have now systematically developed outreach strategies to veterans.
- Persons returning from recent deployment are not always comfortable providing information about their military status in a health care setting, possibly out of concern that they may be referred elsewhere for needed services.
- There is a continually growing need for training in trauma/PTSD recognition and care throughout King County's human service and public safety systems. As media attention and accurate assessment increases, the extent of PTSD effects can be known throughout the homeless services system and primary care system. This is important because delayed onset may be one of the most important drivers for veterans who become homeless and treatment is essential for long-term stability.

Strategy 3, Activity 1.A
Increased access to behavioral health through Community Health Clinic Providers (non-veterans)

Objective: Increase the physical health, mental health status, and emotional stability of vulnerable individuals and family members in King County.

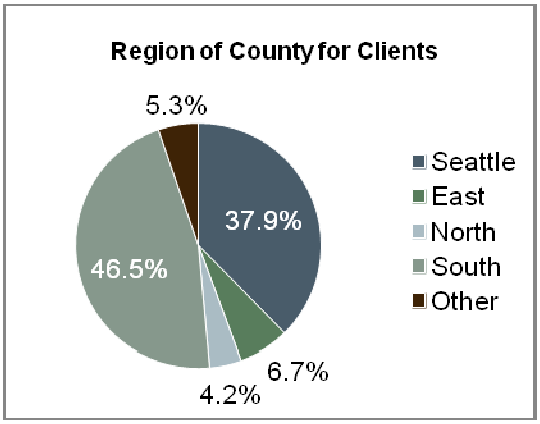
Activity 3.1: Expand the availability of behavioral health services through the integration of mental health care assessment and services into primary care at existing safety net providers (Community Clinics) throughout King County.

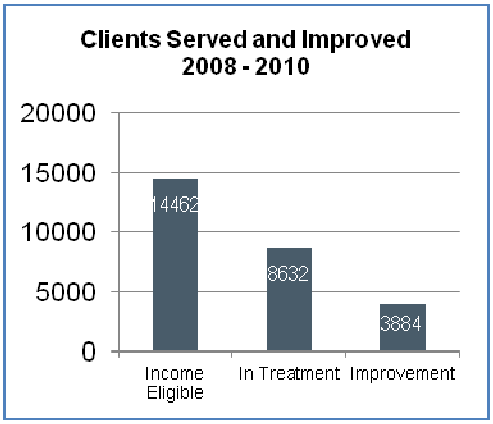
Agencies funded: Funds are subcontracted through Public Health-Seattle and King County to the King County Safety Net Consortium, which is coordinated by Community Health Plan and the University of Washington, Department of Psychiatry. Consortium members include Country Doctor, HealthPoint, International Community Health, Harborview Medical Center, Neighborcare Health, Public Health – Seattle & King County, Sea Mar Community Health Centers, and Seattle Indian Health Board. Eight consortium members manage 26 clinic sites.

Performance 2008 - 2010

- A total of 14,462 low-income eligible health center clients were screened for depression, mental health, and substance abuse issues during primary care visits.
- A total of 8,632 clients (60 percent) who were screened, received comprehensive assessment and treatment through integrated programs in safety net clinics.
- A total of 26 safety net clinics offered expanded integrated care capacity.

Services provided: The integrated treatment model uses protocols to identify and improve common mental disorders. Patients in need of treatment for chemical dependency are referred for treatment. Patients with severe or complex mental health needs are referred to licensed mental health community centers for more intensive services. Collaborative, graduated care is coupled with a robust, online patient tracking system to coordinate care between primary care and mental health/chemical dependency providers. Improved communications ensure better clinical outcomes and conserve program resources.





Measured outcomes – 2010

- A total of 45 percent in 2010 of individuals in treatment experienced clinical improvement and their symptoms of depression and/or anxiety decreased. This is an improvement from 38 percent through 2009. Given the complexities and challenges of the population served, this success rate is very promising and is higher than was anticipated.
- Psychiatric consultation was provided for 61 percent of high-risk individuals, whose cases were active during the fourth quarter of 2010, continuing an increasing trend since the third quarter of 2008.

Client story: Don is a young adult male patient struggling with bipolar disorder who was very reluctant to take medications. He had adverse reactions to medications in the past and was discouraged and unemployed. He was losing his housing and had very few social supports. He had job skills and a work history, but had been fired because of behaviors associated with his mental illness. In addition, he was unable to concentrate well enough to look for employment. The care coordinator was able to convince him to try again with medications. Through psychiatric consultation to choose the right medication, as well as persistence on the part of both the care coordinator and his primary care provider, he was able to stabilize his mood and behavior. Don has recently obtained employment and has a stable income and stable housing.

Evaluation questions

How was the program expanded with levy funding?

Levy funds provide support to implement new integrated mental health services in 26 safety net clinics located throughout King County, encompassing all community health centers and the Harborview Medical Center outpatient primary care. All clinics except Eastgate Public Health Center implemented services prior to the beginning of 2009; Eastgate services were implemented in March 2009.

Who has been served through this program?

A total of 14,462 low-income adults were screened for depression, anxiety, PTSD, and/or substance abuse in their primary care clinic. Of those screened, 8,632 had significant mental health symptoms and were engaged into treatment. They were also receiving a comprehensive clinical assessment, social work, and individual counseling services.

Over 3400 persons served by the program were homeless. Screening and intervention services were concentrated among adults 35 years to 59 years.

How effective have services been?

Of the high-risk individuals active during the last two quarters of 2010 who had at least two depression and/or anxiety screening scores, 45 percent showed clinical improvement in either anxiety or depression, as reflected in a 5-point or greater decrease in the PHQ-9 or GAD-7 between their first and most recent scores.

Lessons learned

- The collaborative care model of integrated treatment is most effective if the primary care team has a full-time (or nearly full-time) mental health clinician to support the use of coordinated guidelines and evidence-based treatment protocols in the clinic.
- The protocols focus on identifying and improving common mental disorders such as depression.
- The model requires approximately two hours per week of consulting psychiatrist time per full time mental health provider to provide guidance on complex patients.

Strategy 3, Activity 1.B
Increased Access to Behavioral Health through Community Health Clinic Providers (veterans)

Objective: Increase the physical health, mental health status, and emotional stability of vulnerable veterans and family members in King County.

Activity 3.1: Expand the availability of behavioral health services for veterans and their dependents through the integration of mental health care assessment and services into primary care at existing safety net providers (community clinics) throughout King County.

Agencies funded

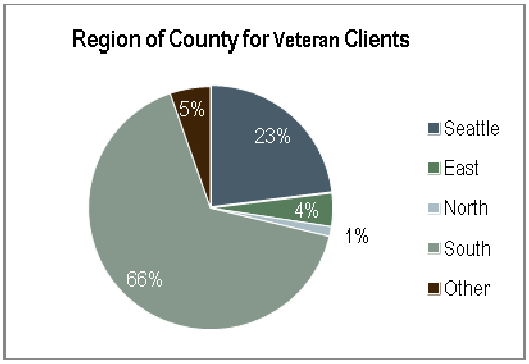
- Funds are subcontracted through Public Health Seattle-King County to HealthPoint, Valley Cities Counseling and Consultation (mobile outreach), Neighborcare Health, and the Seattle Indian Health Board.

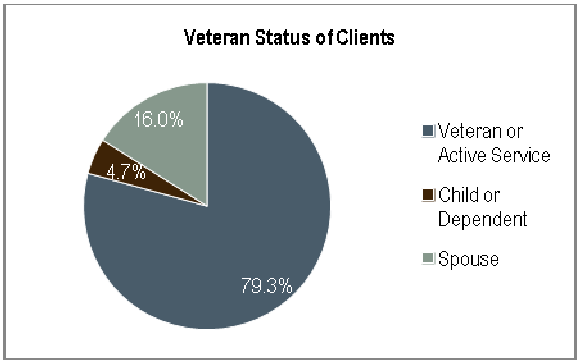
Performance 2008 – 2010

- A total of 1786 veterans and family members were served, with 1575 assessed.
- A total of 1130 veterans' family members who screened positive for PTSD, depression, or other mental health concerns received comprehensive assessment and treatment.
- A total of 596 veterans and family members received specialized case management and referral services through mobile outreach services.

Services

The community clinics piloted and expanded integrated mental health services for veterans. These services enhance mental health staff resources, allowing health centers to build specialized expertise in addressing the needs of military personnel and their families. Levy funds also support a Valley Cities Counseling and Consultation mental health clinician with expertise in war trauma to provide consultation to primary care providers on appropriate screening and treatment. Valley Cities Counseling and Consultation staff also provide screening, mobile outreach and case management to veterans in numerous King County communities.





Measured outcomes - 2010

- Psychiatric consultations were provided for 61 percent of clients in treatment, ensuring appropriate and timely medication management in primary care.
- A total of 159 veterans (41 percent of those eligible to measure) experienced clinical improvement and their symptoms of depression and/or anxiety decreased.
- Eight health centers in suburban King County and one health center in Seattle offer expanded capacity to serve veterans.

Client story: Jane is a 61-year-old female veteran who screened positive for anxiety and depression during a routine primary care visit. When she met with the mental health care coordinator, Jane revealed that she has a significant trauma history being abused as a child and in a long-term domestic violence relationship as an adult. She served in the Army as a nurses' aid. Four years ago, Jane started seeing things and hearing voices. She felt controlled by the voices, and when they commanded her to cut her wrist, she did it. Jane had two psychiatric hospitalizations in the past four years, but before coming to HealthPoint had not received regular mental health treatment. She started seeing the mental health care coordinator regularly and started on medication to control her depression, anxiety, and psychotic symptoms. Jane's symptoms are now well controlled with medication and behavioral health visits. She is exercising more and working on losing weight. She sees her son and 6-month old grandchild regularly. Jane received support to apply for SHAG housing and now participates in their dinners and social activities.

Evaluation questions

How was the program expanded with levy funding?

The levy supports clinic-based services and mobile outreach services throughout King County. HealthPoint expanded its initial south county focus to include five medical clinics throughout suburban King County. Valley Cities Counseling and Consultation also expanded its mobile outreach strategies and staffing. Seattle Indian Health Board serves American Indians, Alaska Natives, and other populations residing throughout King County, while Neighborcare Health focuses on services to homeless veterans at its Pike market location.

Who has been served through this program?

This activity serves veterans, military personnel, and their families, who are struggling with or at risk of mental illness, substance abuse, homelessness, PTSD, and associated health problems. The needs of veterans' families may shift dramatically during deployment. Target populations tend to be frequent users of King County safety net services, including both primary care and hospital emergency departments. In 2009 and 2010, a combined 21 percent of military personnel and family members served were homeless.

How effective have services been?

In 2010, 41 percent of those completing treatment experienced clinical improvement and their symptoms of depression and/or anxiety decreased. This is up from 38 percent in 2009. Given the complexities and challenges of the population served, this success rate is very promising and is higher than was anticipated in the first two years of program implementation.

Lessons learned

- During implementation, health centers encountered challenges in identifying military personnel eligible for services. Clinics have now systematically developed outreach strategies. Beginning in 2009, specialized outreach was created.
- Those returning from recent deployment are not always comfortable providing information about their military status in a health care setting, possibly out of concern that they may be referred elsewhere for needed services.
- The collaborative care model of integrated treatment is most effective if the primary care team has a full-time (or nearly full-time) mental health clinician to support treatment protocols in the clinic.

Are any changes in the program model anticipated?

No changes are anticipated in the program model in 2011.

Strategy 3, Activities 2 and 3
Trauma Training for Professionals

Objective: Expand access for trauma victims and veterans to appropriate and best practice mental health treatment and support services.

Activity 3.2: Invest in training in trauma-sensitive assessment and treatment for providers of community mental health treatment and support services to veterans' programs.

Activity 3.3: Expand the capability to provide appropriate and effective treatment and support to those affected by PTSD by training mental health providers in PTSD treatment best practice.

Agencies funded: WDVA

Performance 6/1/2009 – 12/31/2010

- A total of 2076 treatment providers and non-treatment providers were educated about trauma and delivery of appropriate services.
- In 2010 91 trainings were conducted, 38 to community members, and 53 to clinical providers.
- A post training survey was created to further evaluate the trainings. Results are currently being evaluated. This will garner information about new services and providers. Ancillary data indicates that appropriate referrals have increased because of trainings conducted. The referrals to services have increased to the providers of veteran and military services, evidenced by increased referrals
- Data from trainings indicate there is a high number of attendees that can identify and address trauma in the non-veteran populations, and they continue to learn veteran specific trauma from the trainings attended. The common theme in responses is that more training is desired. Number of primary care providers, behavioral health providers in the mental health and substance abuse systems, and housing support providers who can identify and address trauma and PTSD in both the veteran and non-veteran populations are included in the survey results.

Services provided through 2010

By the end of 2010, 2076 individuals have been trained in trauma care, military and veteran culture, and Post-Traumatic Stress Disorder (PTSD) treatment, traumatic brain injury and military and veteran resources. The number trained represents groups including; first responders, law enforcement, mental health and chemical dependency providers, municipal attorneys, educators, tribal representatives and military and veteran family members. In addition, the WDVA conducted a community conference for King County service professionals.

Most Recent Measured Outcomes

Outcomes are varied for this strategy, and are being measured through numbers of trainings, number of attendees and attendee survey responses to trainings and the yearly conference. The first conference was held in November of 2010, with over 400 attendees. The survey responses of those that attended were overwhelmingly positive for all areas, including the content, and organization of the event. This conference was a collaboration of King County, Washington Department of Veterans Affairs and Veterans Affairs VISN 20. The presenters represented experts in the fields of Trauma treatment, Post-Traumatic

Stress Disorder (PTSD), Traumatic Brain Injury (TBI), Military Sexual Trauma (MST), and Military Culture (MC).

The contract provider has exceeded the numbers of required trainings and service hours for this strategy.

Success story: The WDVA has been conducting trainings at numerous agencies involving multiple systems. From Law Enforcement to Mental Health systems, the trainers have responded to the unique needs of the group being trained. This project has continued to increase the number, type, and depth of trainings available to our community. WDVA has responded to the requests of the community for specific topics that can evolve from traumatic experiences. One such example is responding to the requests for training on Suicide prevention and services.

The suicide rates among veterans and military members continue to rise and with that the need to focus on prevention and awareness. Traumatic experiences in the military and civilian world can lead to the hopelessness that can elevate to suicide. From the partnership with the WDVA and the VA, we developed a new training for suicide prevention and awareness that is available to our community members and providers. This effectiveness is evident in the responses to the trainings, such as comments from the attendees and the requests for additional trainings.

Evaluation questions

How was the program expanded with levy funding?

Program expansion was initiated in June 2009. The WDVA has been able to increase the number of trainings and expand to additional systems of care in 2010. The WDVA has expanded the numbers of trainers, trainings and types of trainings.

Who has been served through this program?

Through 2010, the levy-funded portion of the program had served 2076 individuals. These individuals represent educators, law enforcement, service members, family members, first responders, tribal representatives, mental health and chemical dependency providers.

How much service has been provided?

In 2010, 91 trainings were conducted, 38 to community members and 53 to service providers.

How effective have services been?

The WDVA has had consistent positive reviews of the trainings and requests for follow-up support and additional trainings. The two-day conference in November 2010 had very positive responses to the survey that was conducted. This last year has seen an increase in numbers of trainers and trainings conducted.

Lessons learned

- Not all providers and community members are aware of the needs of veterans and their families or how it may impact the services that they provide to them.
- Incentives and communication with the provider associations may improve penetration of service

Are any changes in the program model anticipated?

The WDVA will be expanding the number of trainers, and modality of training types available, such as web based training. An increase in the breadth of clinical training will be advanced during the next period. Data collection and service evaluation will be consolidated to improve feedback from participants.

- The number of new service providers and referrals of clients to trauma treatment services (too early to measure).
- Number of primary care providers, behavioral health providers in the mental health and substance abuse systems, and housing support providers who can identify and address trauma and PTSD in both the veteran and non-veteran populations (too early to measure).

Strategy 3, Activity 4
Increased Access to Behavioral Health for the Chronically Ill and the Elderly

Objective: Improve the mental health status and independent housing stability of vulnerable elderly veterans, their partners, and other elderly persons.

Activity 3.4: Invest in services to treat depression in chronically ill and disabled elderly veterans, spouses, and other elderly persons by investing in depression counseling and education.

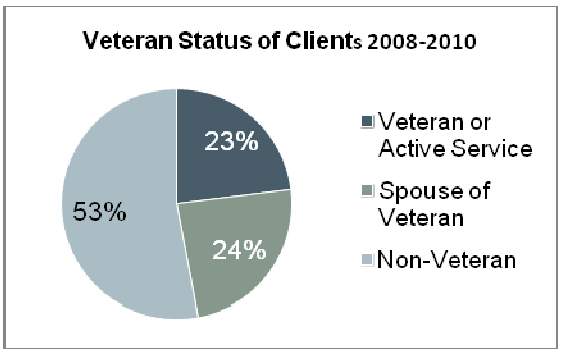
Agencies funded: City of Seattle Aging and Disability Services subcontracting with Catholic Community Services' African American Elders Program and the international Drop-in center.

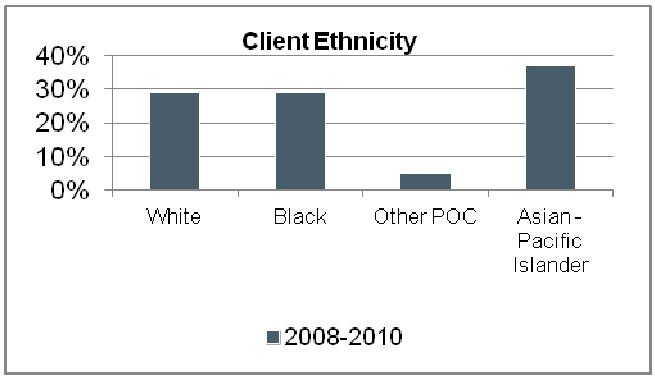
Performance measures 2008-2010

- A total of 551 participants have been recruited by the program.
- A total of 275 clients enrolled in the program.
- A total of 195 (71 percent) clients are persons of color.
- A total of 128 (47 percent) clients are veterans, or the spouse of a veteran.

Services provided

The Program to Encourage Active, Rewarding Lives for Seniors (PEARLS) is a counseling program that teaches depression-management techniques to older adults who experience minor depression. The program provides older adults who are experiencing symptoms of minor depression with eight in-home sessions of a multimodal treatment that includes problem solving, pleasant events scheduling, psychiatric oversight, supervision, and medication management. Once completed, clients receive up to three months of follow-up phone calls. By the completion of the program, a significant number of clients are able to better identify solutions to problems. Not all of the older adults served by this strategy will end up enrolled in the PEARLS program; some will be referred to other programs or services in the community.





Most recent measured outcomes

Of the 165 clients assessed at pre/post services in 2009 and 2010 (after six to nine months in program), 98.5 percent showed improvement in depression assessment scores (note that some who were assessed began the program in 2008).

Client story: Mr. Fair was referred to PEARLS by a case manager of Frederick Ozanam House, a program of Catholic Housing Services that opened in 2009 for chronically homeless men. Like most of the Ozanam House residents, Mr. Fair is a veteran. A recovering drug addict, who had been homeless, Mr. Fair has begun to take charge of his life and use the PEARLS problem-solving techniques and activity planning to counter the negative factors he contends with almost daily.

Mr. Fair provides an example of the insidious nature of chronic depression. He was candid with his caseworker in describing how even living among other depressed persons can affect one's attitude and morale. However, although he may continue to cope with symptoms of depression in the future, it is clear that Mr. Fair has moved closer to self-empowerment by acquiring new skills through PEARLS.

Evaluation questions

How was the program expanded with levy funding?

During 2008, Aging and Disability Services (ADS) added a part-time counselor, and contracted with two community providers, the international drop-in center and Catholic Community Services' African American Elders Program. The ADS reports that the agencies stated the program was successful in communities of color when the appropriate level of support was provided. In 2009, ADS reduced their internal staff position and increased the support to the community providers to serve more people.

Who has been served through this program?

During 2009, a total of 168 unduplicated older adults were screened by PEARLS through recruitment, enrollment, treatment, or by being referred for other services. In 2009, 81 clients enrolled in the program and 78 completed the program. (Please note that these numbers are rolling, in that a client may enroll towards the end of 2009, but not complete the program until 2010.)

The ADS focused levy resources on providers that could primarily serve communities of color. The result was an increase in the percentages of Asian/Asian American clients and a decrease in the number of Caucasian participants: 52 percent of the people enrolled in 2009 were Asian/Asian Americans, 33 percent were Black/African Americans, 10 percent were Caucasian, 2.5 percent were Hawaiian Native or Pacific Islander, and 2.5 percent were Hispanic/Latino.

Of those enrolled during 2009, 49 percent were non-veterans, and 51 percent were veterans, or spouses of veterans.

How effective have services been?

Of the 551 participants recruited in 2009, 275 (50 percent) were enrolled into the program. This is a much higher rate than the original model in 2008 anticipated (37% enrollment). One hundred sixty-five enrollees completed the program by the end of 2010. About 98 percent of those who completed the program showed improvement on the Patient Health Questionnaire (PHQ), a nine-item depression scale. The PHQ scale assesses symptoms and functional impairment in order to make a tentative depression diagnosis, and then derives a severity score in order to help select and monitor treatment.

Lessons learned

- The project has been successful due to adherence to the evidence-based model established prior to this expansion.

- The approach has mainly focused on clients and resources based in Seattle. As a result, a majority of clients are from the Seattle area.

Are any changes in the program model anticipated?

Providers will continue to focus their attention on outreach to communities of color. Increased emphasis will be placed on recruiting people living in east and South King County.

Strategy 4 Overview
Strengthening Families At-risk

Objective: Enable at-risk families and their children to thrive by promoting family stability and effective child development.

Strategy overview: Critical needs for families include strong maternal-child attachments, economic self-sufficiency, and connection to community and/or extended families and other indigenous supports. Many families in King County face circumstances that make these conditions unlikely, putting them at increased risk of involvement in child welfare, behavioral health treatment, or justice systems.

Strategy 4 activities focus on early intervention and prevention, and are based on either evidence-based or promising practices. These activities focus on young first-time mothers, single parents exiting the criminal justice system, and recent immigrants who are isolated from services and face linguistic and/or other cultural barriers to participation in community life. Each activity builds on successful programs and initiatives provided in different areas of King County. Resources have been allocated to accomplish three overarching objectives within Strategy 4, with a number of activities designed to meet the objectives as follows:

Support maternal-child attachment and maternal health

- Expand Nurse Family Partnership and add linkages to employment opportunities
- Pilot new services for maternal depression.

Support healthy early childhood development and parenting

Expand the availability of programs that promote healthy early development through responsive, nurturing caregiver-child relationships and improve language and culturally based access to services

Provide early intervention and supports for parents exiting the criminal justice system

- Provide service enhancements for single parents exiting the criminal justice system, who are living in transitional housing
- Invest in education and employment programs for single parents exiting the criminal justice system
- Provide treatment for parents involved with the King County Family Treatment Court for child dependency cases.

How have levy resources been used to meet these objectives?

Most of the activities within Strategy 4 build on programs or models that existed in the community prior to the availability of Human Services Levy funds. All Strategy 4 activities are funded by the Human Services portion of the levy. Total funds expended through 2010 are $7,159,951 of Human Services Levy funds. Table 2-7 summarizes how levy resources have been used to support strategies to strengthen families since levy implementation began through 2010

Table 2-7: Strategy 4 Activity Resources Used						
Activity		Lead Implementing Agency	Date of First Service	Clients Served through 2010	How were levy resources used?	Expenditures through 2010
Support maternal-child attachment and maternal health						
4.1	Nurse Family Partnership	PHSKC	2008	**506**	Expanded team capacity to add 133 slots for mothers annually	$2,044,600
4.1	Nurse Family Partnership-Employment-Education Support	WTP	2009	**269**	Supported 2 FTE employment education specialists who worked with NFP enrolled clients	
4.2	Pilot services for maternal depression	PHSKC	2008	**8,392**	Pilots a new interdisciplinary team of professional screen, assess and provide therapy and peer support groups at nine clinic sites	$1,741,638
Fund early childhood and prevention services						
4.3.A	Healthy Start expansion	PHSKC	Jan 2008	**1,661**	Added eight full-time employee healthy start staff and new Management Information System. A new agency serving South King county was brought on board	
4.3.B	Cultural Navigator project	PHSKC	June 2008	**2,555**	Expanded staff hours to conduct outreach to agencies	$1,793,489
4.3.C	Promoting First Relationships project	PHSKC	2009	**31 staff trained**	A training agency (University of Washington) was contracted to provide training for care giving professionals	
4.3.D	Family Friend and Neighbor Network Play and Learn	PHSKC	July 2008	**25,190**	An agency was contracted to improve curriculum materials, and train volunteer Play and Learn facilitators	
Provide early intervention and supports for parents exiting the criminal justice system						
4.4/4.5	Invest in education/employment/treatment for parents exiting CJ system	CSD	Jan 2009	**176**	Two agencies contracted to provide comprehensive services in permanent housing.	$837,952
4.6	Family Treatment Court	King County Superior Court	Jan 2009	**121**	Levy funds three positions: Program Supervisor, Court Specialist, and Court Appointed Special Advocate Supervisor, along with a three-year outcome evaluation.	$742,271
Total Strategy 4 Clients				**38,901**	**Total $ Strategy 4**	**$7,159,951**

How has levy funding helped families at-risk?

Each Strategy 4 activity that has been implemented by 2010 has been evaluated, and these evaluations are presented in Section 3, specifically focusing on results achieved through the life of the levy. Levy funds have significantly expanded programs serving at-risk families. Over $7,159,951 has been expended for additional behavioral health services for 38,901 persons through 2010. While each activity's accomplishments are summarized in Section 3 of this report, some overall statistics offer insight into the levy's broad impact.

Support maternal-child attachment and maternal health

Over 7,100 mothers have been screened for maternal depression, and 685 have received behavioral health treatment services that will contribute to the healthy development of their children. Of those

measured, 68 percent have reduced depression and/or anxiety, improving the likelihood of their successful parenting.

Support healthy early childhood development and parenting

Over 10,980 new parents have increased their education and support to ensure they get the resources and skills they need to raise healthy children.

Provide early intervention and supports for parents exiting the criminal justice system

Eighty-three justice system-involved parents have received intensive treatment and services to help them reunite with and/or create healthy relationships with their children.

Table 2-8 presents a summary of the 2009 achievements for each separate activity.

Table 2-8: Strategy 4 Activity 2008-2010 Performance

Activity		2009 Services		Outcomes	
		Types	Through 2010 Quantity	Outcome Measures	Results
Support maternal-child attachment and maternal health					
4.1	Nurse Family Partnership	Clients enrolled NFP Clients enrolled WTP	267 238	Successful birth outcome Improved employment	90 percent 68 percent
4.2	Pilot services for maternal depression	Clients screened Positive for depression Receiving treatment	6,979 2140 1479	Increased mental health status	64 percent
Fund early childhood and prevention services					
4.3.A	Healthy Start expansion	Clients assessed Receiving home visits Linked with medical	998 998 972	Delaying birth of second child	91 percent
4.3.B	Cultural Navigator project	Clients receiving info Information contacts Agencies - technical assistance	3390 4153 367	Increased access to culturally appropriate services	92 percent
4.3.C	Promoting First Relationships project	Number of caregivers trained	31	Increased caregiver skills	67 percent
4.3.D	Family Friend and Neighbor Network Play and Learn	Families served Attendees Play and Learn	9,233 33,227	Increased caregiver skills	83 percent
Provide early intervention and supports for parents exiting the criminal justice system					
4.4/4.5	Invest in education / employment / treatment for parents exiting CJ system	Parents served Case management hours	93 9906	Families do not re-enter the CJ system	100 percent of those measured did not return
4.6	Family Treatment Court	Clients served New enrollees with treatment plan	121 64	Completed treatment plans	88 percent

What lessons have been learned?

- There is a high demand for many services funded under Strategy 4.
- Evidence-based practice is showing that early interventions in the first two years of a child's life have tremendous positive impact on the long-term prospects for childhood development.
- The Nurse Family Partnership is effective and follows the national best practice model, meeting fidelity measures for enrollment and visit completion rates, and excels in client retention rates as compared to national rates.

- Rates of maternal depression are quite high among younger parents and low-income persons of color.
- The ability of nurse home visitors to follow clients throughout the county contributes to client retention and overall success serving a transient population.
- There is a tremendous demand in the community for increasing training personnel in the Promoting First Relationships Program. Numerous community-based agencies have expressed the need to increase their service capabilities and get staff trained.
- The Cultural Navigator Program has been successful at increasing support and overcoming isolation for parents who face cultural barriers to service.
- The Family Treatment Court (FTC) program is very effective at creating positive treatment outcomes for parents, giving them the opportunity to reconcile with their families.

Strategy 4, Activity 1.A
Nurse Family Partnership home visiting

Objective: Enable at-risk families and their children to thrive by promoting family stability and effective child development.

Activity 4.1.A: Increase the health status of first-time mothers and their children by providing access to health care coverage through in-home visitation services. Reduce child abuse and neglect among first time, low-income young mothers in King County. Improve long-term family economic stability for first time, low-income young mothers in the Nurse Family Partnership (NFP) Program.

Agencies funded: Public Health - Seattle & King County, King County Work Training Program.

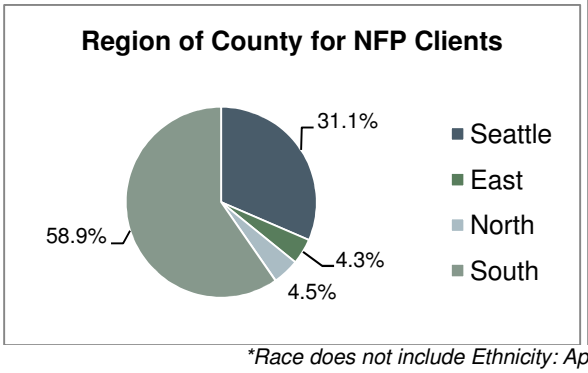
Performance 1/1/2008 – 12/31/2010

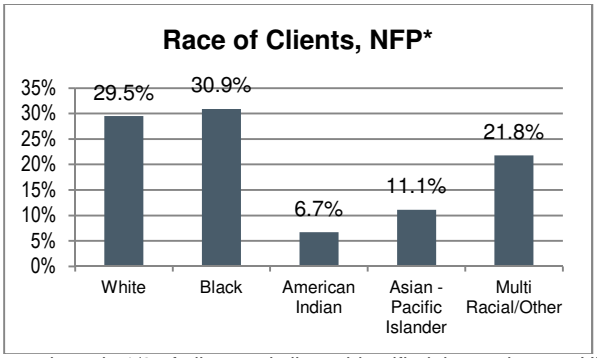
- A total of 506 low-income first-time mothers were served in VHS Levy funded NFP services through 2010 – 267 enrolled in NFP and 238 were enrolled in education/employment services provided by King County Work Training Program (WTP).
- A total of 10 of these 133 clients moved or were closed to services before the end of 2009.
- A total of 33.5 percent of the NFP clients were homeless.

Services provided

The NFP is a national evidence-based home visitation program that focuses on improving the lives of first-time mothers and their children. The NFP services target young women age 23 or younger, at or below 185 percent of the federal poverty level and having their first babies. Priority is given to clients under 20 as evidence based research has shown they are likely to most benefit from the NFP services. Clients are enrolled during pregnancy to allow time for the public health nurse and client to establish a relationship before the baby is born. Clients receive a home visit about every two weeks from the time they enroll until their first child's second birthday, with visits that are more frequent right after enrollment and after the baby is born.

Visits and services are customized to each client's needs, although all clients use a common curriculum called Partners in Parenting Education (PIPE). Visit content is determined by phase (pregnancy, infancy, and toddler) and by the client's goals and needs. Clients are referred to Friends of Youth or King County Work Training Partnership program for education, employment and training, or other services.





**Race does not include Ethnicity: Approximately 1/3 of all served clients identified themselves as Hispanic.*

Measured outcomes

- Annual success rates ranged between 89 percent and 91 percent of the clients delivered an infant at term and at a weight greater than 2,500 grams in 2009.
- All families who were identified as exhibiting parental stress were offered support around the parent/child interaction, were helped to access and engage in behavioral health services, and were referred for parenting classes or parenting support in the community.
- Over 68.5 percent of the clients engaged through the WTP achieved secondary education, higher education or improved employment.

Client story: Jane, a 16-year-old, lives at home with her mom and dad. Although she had experimented with drinking and drugs, Jane was excelling in high school until she was told it was not the place for her because she was pregnant. Jane's boyfriend was on house arrest and would soon be serving time in jail.

Jane struggled with grief and depression in the early days after her son's birth. Her NFP visits focused on how her infant responded to her. A turning point came when her son was three weeks old. He had been crying inconsolably and Jane was frustrated. She put him in his bed so she could calm herself (she had made a plan to prevent Shaken Baby Syndrome). Once calm, she got a children's book, picked up her baby and showed him the pictures. He calmed! She recognized her abilities.

When her son was four months old, Jane's family moved to Snohomish County. She is providing the majority of her son's care, getting support from her family as needed. She has regular contact with the baby's father, who has four more months of incarceration. Jane is back in school, doing well.

Evaluation questions

How was the program expanded with levy funding?

The VHS Levy purchased slots for families in need – between 15 and 20 percent of total annual capacity. The project began services in the 3rd quarter 2007. The NFP reached its full caseload of 133 clients early in the second quarter of 2009 and continued to replace clients as capacity is created by clients moving, graduating or terminating services for other reasons. Clients enroll as early in pregnancy as possible, but no later than 26-28 weeks gestation, and are followed until their infant reaches age two. Beginning in 2009, two full-time Work Training Program staff were funded by the Human Services Levy and the Children and Family Commission

Who has been served through this program?

- The NFP serves a very young, transient population. In 2010, 41 percent of NFP clients reported being homeless, an increase from 29 percent in 2009 and 22 percent in 2008.
- Over one-third of the clients were under 18 (36 percent), over 75 percent were persons of color, and over one-third of those who identified their ethnicity were Hispanic.
- The Work Training Program served 116 NFP clients in 2009.

How effective have services been?

- Over 90 percent of NFP clients delivered an infant at term and at a weight greater than 2500 grams, exceeding the target of 85 percent of clients.
- A total of 99 percent of clients reported that they were satisfied (15 percent) or very satisfied (84 percent) with the program.

- A total of 96 percent of clients found the NFP nurse supportive, 91 percent found the nurse understanding and respectful.
- In 2010, 116 of 153 parents (75.8%) engaged in work or school. Most were using the time of the pregnancy and with newborn children to focus on education and attaining work credentials for future careers when they reenter the workforce.

Lessons learned

- The program is effective and follows the national Best Practice model, meeting fidelity measures for enrollment, and visit completion rates and excels in client retention rates as compared to national rates.
- The ability of nurse home visitors to follow clients throughout the county contributes to client retention.
- The NFP/Work Training Program model works very well as a holistic approach to services. The nurses are able to assist young mothers with child development and parenting, while the Work Training Program social workers are able to help them with education, employment, and training.

Are any changes in the program model anticipated?

No changes are anticipated in the program model in 2011.

Strategy 4, Activity 2
Addressing maternal depression of low-income mothers

Objective: Enable at-risk families and their children to thrive by promoting family stability and effective child development.

Activity 4.2: Pilot integrated mental health service strategies to address maternal depression among low-income mothers who are served by maternity support programs and health centers.

Agencies funded: Through subcontracts with Public Health - Seattle & King County, by 2010 ten pilot clinic sites managed by six agencies were participating. They include Country Doctor Community Health Centers, HealthPoint, International Community Health Services, Neighborcare Health, and SeaMar Community Health Centers.

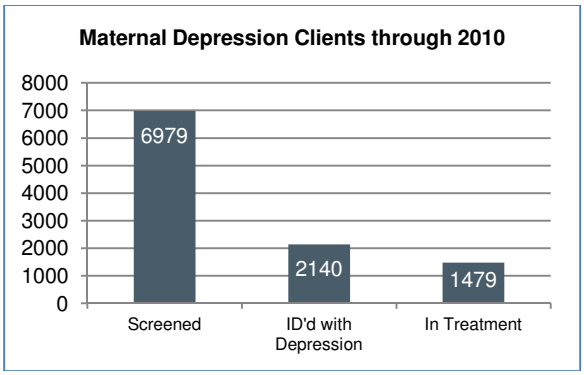
Performance 5/1/2008 – 12/31/2010

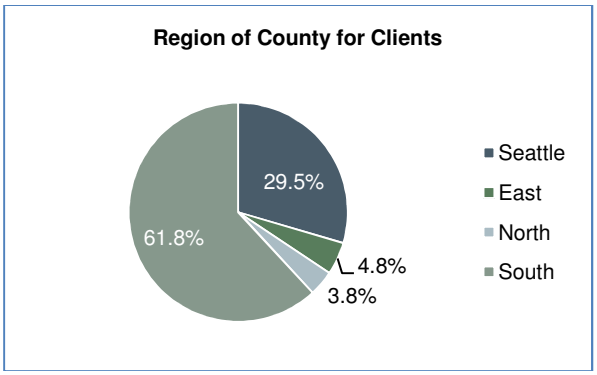
- A total of 6,979 pregnant, parenting women and children were screened for mental health concerns.
- Of this number, 2,140 women (30.6 percent) screened positive for significant clinical depression.
- Of the women who had symptoms of significant depression, 1,479 (69.1percent) elected to receive treatment and follow up.

Services provided

Clinics participating in the pilot program are using a collaborative, stepped care model to deliver services to identify and treat depression and other common mental health disorders. This evidence-based integrated practice model guides nursing, primary care, and mental health providers to collaborate successfully to diagnose and treat depression in primary care clinics. The primary care team uses a coordinated set of guidelines and evidence-based treatment protocols that are designed to identify and improve common mental disorders such as depression. In addition, a consulting psychiatrist is available to consult with primary care staff.

Collaborative, stepped care is coupled with a robust, online patient tracking system to coordinate care between primary care and mental health/chemical dependency providers. Improved communications between treating providers ensure better clinical outcomes and conserve program resources.





Most Recent Measured outcomes 2010

- Of the 284 women enrolled with two or more screenings for depression, 182 (64 percent) had an improvement of five points or more between their first and most recent screenings.
- A total of 128 women had two or more screenings for generalized anxiety disorder symptoms. Of this total, 56 women (44 percent) had an improvement of five points or more between screenings.

Client story: Lin difficulty walking and standing due to a case of polio she contracted as a child. However, she's never let polio get in the way while raising her three children. Unfortunately, Lin encountered an obstacle even more challenging than polio when her husband became abusive. He withheld cash for food and other family needs, and left Lin so fearful she sent her oldest daughter to live with relatives.

Lin did not speak much English and had a very limited support network. Then she learned of the International Community Health Services' Mighty Moms group at the international district clinic. Mighty Moms is a levy-funded educational and peer support group that meets each week to help mothers with family budgeting, parenting skills, domestic violence, and healthy living.

Lin's Mighty Moms group gave her the freedom to talk freely about the abuse she was suffering at home. ICHS staff helped her obtain food stamps for her family and referred her to legal aid through the Refugee Women's Alliance. Lin began receiving individual counseling at the clinic and, with the help of her counselor and Mighty Moms group, is now working toward getting her own apartment for her family. The friendships she has established have given her a network she can reach out to for support.

Evaluation questions

How was the program expanded with levy funding?

This program did not exist before it was identified as a need as part of the planning process for the levy.

Who has been served through this program?

- As many as 13 percent of women experience depression during the prenatal period, and estimates of the overall prevalence of depression among mothers of young children range from 12 percent to 50 percent.
- This project screened more than 6,900 low-income, high-risk people. Over 1,400 women with clinical symptoms were engaged in interventions.
- Interventions were provided throughout King County in ten community health center clinics.
- Over 67 percent of the clients screened were persons of color.
- About 5 percent of the pregnant or parenting mothers were homeless at the time of screening and 156 veterans were served through 2010.

How effective have services been?

- Of 851 women who had two or more recorded screenings for depression or for generalized anxiety disorder in 2010, 557 (65 percent) had an improvement of five points or more between their first and most recent screening scores. A decrease of five or more points is considered a clinically significant response to treatment.

Lessons learned

- The collaborative care model of integrated treatment is most effective if the primary care team has a full-time (or nearly full-time) mental health clinician to support the use of a coordinated set of guidelines and evidence-based treatment protocols in the clinic. These protocols are designed to systematically identify and improve common mental disorders, such as depression.
- The model also requires around two hours per week of consulting psychiatrist time for this specialist to work effectively with primary care staff, providing guidance on complex patients.

Are any changes in the program model anticipated?

No changes are anticipated in the program model in 2010.

Strategy 4, Activity 3.A
Healthy Start Home Visiting Services

Objective: Enable at-risk families to thrive by promoting family stability and child development.

Activity 4.3.A: Strengthen families by supporting the healthy interactions between parent and child in the early months and years of life by expanding the Healthy Start home visiting program.

Agencies funded: The program funds five agencies through sub-contracts through Public Health - Seattle & King County: Friends of Youth (lead agency), Center for Human Services, Northshore Youth and Family Services, Renton Area Youth and Family Services, and Youth Eastside Services.

Performance 1/1/2009 – 12/31/2010

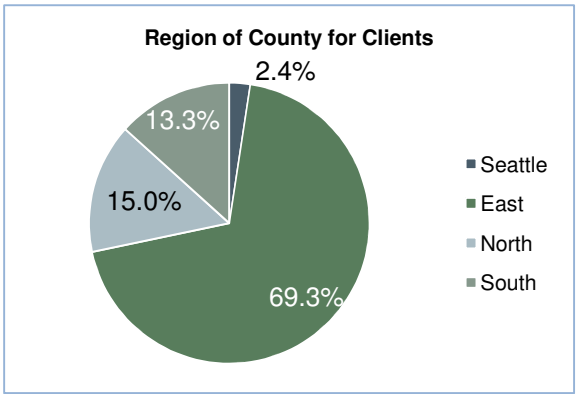
- A total of 650 families were served by Healthy Start in through 2010 through 2,144 home visits.
- A total of 106 (33 percent) of the clients served were 17 years of age or younger.
- All parents who were identified with parental stress had interventions offered.
- All children and pregnant women had access to health care and were linked with a medical provider.

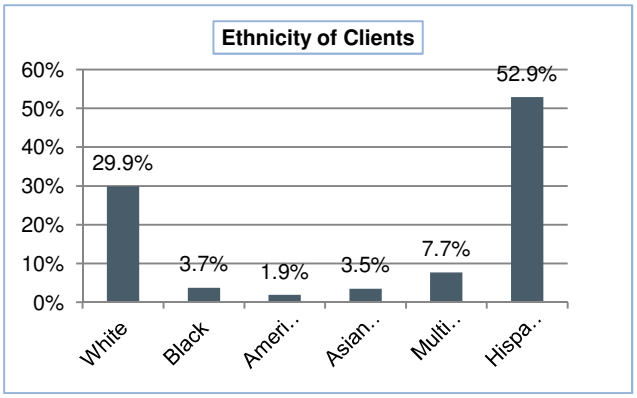
Services provided

The Healthy Start Program is a community collaboration of five non-profit human service agencies that has been providing intensive home visiting services for 16 years. In 2009, Healthy Start expanded with levy funds to serve a total of 335 families throughout the county. The target population is young, at risk, first-time mothers, fathers, and their infants. The majority of participants are very low income.

Healthy Start provides two delivery models: (1) visits conducted by professional Family Support Specialists (FFS) for high-risk families (90 percent of families); and (2) visits by volunteer Parent Mentors who are paired with a family that is lower risk (10 percent of families).

Healthy Start utilizes the evidence-based Parents as Teachers (PAT) Born to Learn™ Prenatal to Age 3 program model. The PAT model was assessed by the Washington State Institute of Public Policy as having statistically significant benefits to society relative to its costs.





Most Recent Measured Outcomes 2010

Healthy Start served a total of 315 families in 2010. Outcomes experienced by program participants include:

- 92 percent increased their healthy effective parenting skills
- 94 percent strengthened their nurturing and attachment behaviors
- 97 percent of participants and children did not experience domestic violence and/or child abuse & neglect
- 98 percent increased their families independence
- 92 percent delayed a second birth by more than 24 months

Client story: In November of her junior year, Keisha discovered that she was pregnant. She did not know what to do, and to make things worse, her parents kicked her out of the house. Keisha dropped out of school, moved into her boyfriend's apartment, and got a job at McDonald's. Because she was under 18, she could not qualify for welfare or subsidized housing, and could not even open her own bank account. Instead, she gave her paychecks to her boyfriend, who cashed them for her.

Then Keisha found the levy's Healthy Start Program. Her home visitor addressed Keisha's homelessness, helping her reconcile with her parents. She helped Keisha enroll in a General Education Development (GED) program. After Keisha's son was born, her counselor shifted the focus to parenting skills and helped Keisha become a confident young mother. Keisha decided to work toward her dream of becoming a nurse, and quickly passed her GED and finished a medical assistant training program.

Evaluation questions

How was the program expanded and enhanced with levy funding?

Levy funds have allowed a number of major program enhancements. Funds have been used to lower home visiting caseloads to the optimum recommended (25 families) and implement a new data management system. Expansion efforts included serving 25 families in the Renton area through a new Healthy Start partner, Renton Area Youth and Family Services. The program was also able to implement a new computer database system that allows easy tracking of participant outcomes. Individual and program-wide outcomes can be obtained without difficulty through this reporting program.

Who has been served through this program?

Through 2010, fifteen family support specialists and 41 trained volunteer parent mentors served 650 families, with a total of 1,304 members. Services available to families included home visiting, support groups, child development education, peer mentoring, family advocacy, information and referral, health information, emergency assistance, parenting/child development education, well baby care and assessment, bilingual/bicultural staff, and economic development services. Over 70 percent of clients are people of color, with close to half of all clients (52%) being Hispanic ethnicity. Approximately one fourth of all parents were under 18 (154 of 650 parents)

How effective have services been?

The program met or exceeded all of its performance indicators:

- A total of 92 percent of participating parents delayed their second pregnancy for a minimum of two years.
- A total of 97 percent of participating families were not involved in reported domestic violence or child abuse.

- All those who are identified with parental stress had interventions offered.
- All participants had access to health care and were linked with a medical provider.
- A total of 90 percent of the parents participating in the program reported decreased parental stress.
- A total of 97 percent of parents participating in the program reported feeling more confident in their parenting skills.

Lessons learned

- Demand for services remains high in the Renton area, with waiting lists.
- The new computerized database allows easy tracking of individual and program wide outcomes.
- Family Support Specialists report that a reduction in caseloads from over 30 families to 25 families has allowed them to meet the needs of each family better.
- The ability to use levy funds to build on an existing successful program provided an opportunity to expand the program into a new community and provide high quality services with measurable outcomes within the first year of funding.

Are any changes in the program model anticipated?

No changes are anticipated in the program model in 2011.

Strategy 4, Activity 3.B
Cultural Navigator

Objective: Enable at-risk families to thrive by promoting family stability and child development.

Activity 4.3.B: Strengthen families by supporting the healthy interactions between parent and child in the early months and years of life by providing cultural navigators for minority and immigrant populations.

Agencies funded: The program is funded through a sub-contract through Public Health - Seattle & King County with Chinese Information Services.

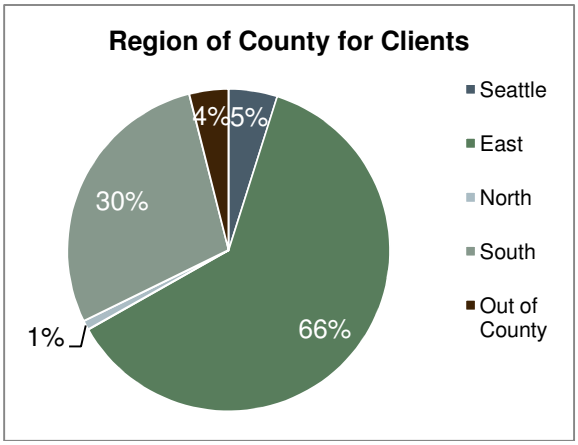
Performance 1/1/2008–12/31/2010

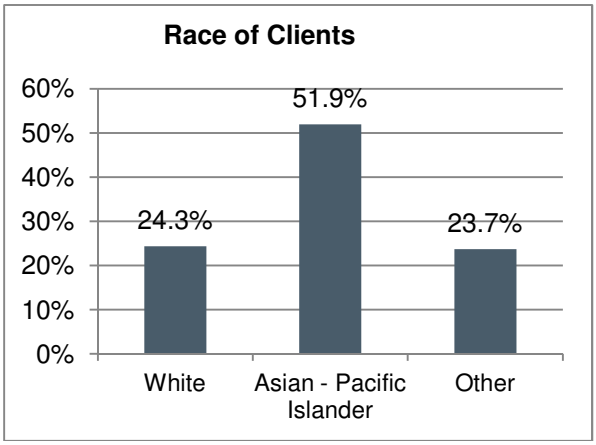
- A total of 2,555 clients received information and referral, with 4,153 information contacts
- A total of 367 agencies received technical support and training.

Services provided

The Cultural Navigator Program helps limited- and non-English speaking individuals and families to access appropriate services and navigate through those service systems. There are three different service locations for the project: the Crossroads Mini City Hall in Bellevue, Family Resource Center in Redmond, and the Great Wall Mall in Kent. Services are provided by bilingual/bicultural staff in Chinese (Mandarin and Cantonese), Spanish, Vietnamese, Russian, and Punjabi. Services are provided individually, in small groups, and workshop format.

Activities include referral and information, completing applications and forms, family support services, reference materials, limited interpretation and follow-up, and Play and Learn groups.





Measured outcomes

- A total of 2,555 clients received information and referral.
- A total of 94 percent of participants indicated that the Cultural Navigator project increased their access to culturally and linguistically appropriate services and resources in the community.
- The Cultural Navigator project staff was in contact with a total of 367 individuals from community agencies for consultation, collaboration, and the sharing of resources. This included members of non-profit groups and agencies, government, schools, the medical field, and others.

Client story: Mara came to a Cultural Navigator appointment because she was not able to take a step on her own. She came to the U.S. with multiple medical problems. While she was living in her country, she underwent surgery on her thyroid gland. From that point on, her health deteriorated. She could not walk because her hip was affected during the post-operation period. She was not able to work and therefore was not eligible for medical insurance. Her son also had severe health issues and could not attend a regular school.

Because Mara's husband did work, however, her family was not eligible for medical coupons through Washington State Department of Social and Health Services (DSHS). Mara had tried multiple times, but could not work her way through the paperwork. Cultural Navigator was able to help her complete change-of-circumstances papers for DSHS, qualify for medical coupons, get referrals to specialists, and qualify for surgery. In the meantime, Cultural Navigator helped Mara find an appropriate school for her disabled son. Both are now succeeding and hopeful.

Evaluation questions

How was the program expanded with levy funding?

Cultural Navigator opened a new location in South King County in 2008, and increased hours and services at its two East King County locations. As a result, the number of people served nearly doubled.

Who has been served through this program?

- A total of 2,555 persons have been served, 53 were homeless.
- Over 75 percent of all clients are people of color, with over 50 percent (51.9 percent) Asian. Not surprisingly 1,707 (67%) have limited English-speaking ability although this is a drop from 81 percent in 2009.
- All but five percent were from outside Seattle.
- Many grandparents use cultural navigator, as they live in families in which both parents work.
- A total of 367 agencies have been assisted in serving their clients.
- Individuals, more than families, are becoming the primary users of services.

How effective have services been?

- A total of 92 percent of participants indicated that the Cultural Navigator project increased their access to culturally and linguistically appropriate services and resources in the community.

Lessons learned

- The need for cultural navigation is extremely high throughout King County, but especially in recent immigrant and refugee communities.
- King County has a number of immigrant communities. Immigrants often struggle for the first several years they are here as they attempt to access services and resources.
- There is a need to expand to other immigrant and refugee communities.
- It is important to build upon a community's inherent strengths and seek out trusted natural leaders.

Are any changes in the program model anticipated? No

Strategy 4, Activity 3.C
Promoting first relationships

Objective: Enable at-risk families to thrive by promoting family stability and child development.

Activity 4.3.C: Strengthen families by supporting the healthy interactions between parent and child in the early months and years of life through Promoting First Relationships (PFR) Train the Trainer Program.

Agencies funded: The PFR is implemented through sub-contracts with Public Health - Seattle & King County through the University of Washington, which has trained three non-profit agencies: Atlantic Street Center, Child Care Resources, and Valley Cities Counseling and Consultation.

Performance 1/1/2009 – 12/31/2010

Six agencies have been trained by University of Washington to implement the PFR curriculum with other agencies.

Services provided

The PFR program is a University of Washington-based Train the Trainer project. Three community agencies were selected to receive the Train the Trainer Promoting First Relationships (PFR) education in 2009 and another three in 2010, and some additional staff of a 2009 agency. The PFR curriculum consists of the following elements:

- Theoretical foundations of social and emotional development in early childhood (birth to three years)
- Consultation strategies for working with parents and other caregivers
- Elements of a healthy relationship
- Promoting the development of trust and security in infancy
- Promoting healthy development of self during toddlerhood
- Understanding and intervening with children's challenging behaviors
- Developing intervention plans for children and caregivers
- Individualizing PFRs for your setting.

Measured outcomes – 2010

The three contracted outcomes for the University of Washington – PFR contract include:

- Increased school readiness
- Increased children’s healthy social-emotional development
- Increased responsive, nurturing caregiver relationships.

The content of the PFR curriculum directly addresses the three contractual outcomes. However, the trainee’s ability to provide the curriculum with fidelity is essential to helping families achieve these outcomes. If a trainee successfully masters the curriculum, research has shown that the families they serve will experience the outcomes listed above. Fidelity data and evaluation by the PFR Master Trainer indicate that all three trainees are able to use the PFR model effectively and with fidelity. Two of the three agencies involved in the 2009 training and two of the 2010 agencies received a certificate for program

graduation and are authorized to train other agency staff in PFR. One agency in 2009 did not complete the training due to personnel issues, and one agency in 2010 completed the training but did not receive the certificate as of December 31, 2010.

It is too early in the project to demonstrate the longer-term outcomes.

Client story

While Meeno completed her PFR training, she had the opportunity to observe a 2-½-year-old boy who had been diagnosed with delays in his gross and fine motor abilities. He had not yet shown signs of verbal communication and he did not interact with other children. When Meeno interviewed his teacher, she shared her concern that the boy did not seem aware of his surroundings and that he did not communicate or connect with others. His teacher was genuinely concerned for his well-being and hoped that through PFR he would improve in his behavior. Over the course of their time together as mutual investigators, Meeno and the teacher explored the relationship this child had with his teacher and surroundings. They learned that the child was very aware and actually had his own place in the classroom, as he often perched himself on the top of a small bridge so that he could look over his teacher's shoulder when she read books at story time.

Meeno and the teacher discovered that because of the child's delays, he responded better when treated as a 10-month-old. He responded to a singsong voice and by seeing his teacher's face close up. The teacher was inspired and motivated as she saw the child respond. During this time, the child also began to receive regular physical therapy sessions. Because the teacher was now empowered and knowledgeable, she was able to be an advocate for him with his mother to ensure that he continued to receive services and that the child-care center was included in planning around his developmental needs.

Evaluation questions

How was the program expanded with levy funding?

The University of Washington was awarded $60,000 annually in Strengthening Families funding to provide the PFR Train the Trainer Project to three community-based agencies a year.

Who has been served through this program?

Five agencies now have the capacity to implement the PFR program.

How effective have services been?

The content of the PFR curriculum, if implemented with fidelity, will help families with increased school readiness, increased healthy child development, and increased relationship skills. Agency personnel have been trained and monitored in the curriculum, but it is too early in the project to demonstrate the longer-term outcomes.

Lessons learned

- There is a tremendous demand for PFR program training. Numerous community-based agencies have expressed the need to increase their service capabilities and get staff trained.
- Staff and agencies that are selected and put through the PFR program must be committed to train their staff over the long term. As the PFR-trained staff spread the curriculum through the agency, they must continue to be engaged in ongoing reflective practice with the PFR program staff at the University of Washington.

Strategy 4, Activity 3.D
Family and Friends Network

Objective: Enable at-risk families to thrive by promoting family stability and child development.

Strategy 4.3.D: Strengthen families by supporting the healthy interactions between parent and child in the early months and years of life through the Family and Friends Network (FFN).

Agencies funded: The FFN is implemented through sub-contracts with Public Health – Seattle & King County through Child Care Resources.

Performance 1/1/2008 – 12/31/2010

- A total of 25,190 unduplicated families (consisting of at least one parent/caregiver and child) were served through 2010 in FFN Play and Learn groups.
- At the end of 2010, a total of 72 FFN groups were in operation. Groups are spread all over the county. Many groups are bilingual and bicultural.

Services provided

The FFN is a comprehensive, community-based network of supports and resources for family, friend, and neighbor caregivers and the children in their care. Family, friends, and neighbors provide care for an estimated 60,000 children in King County. For 28,000 of those children, they are the primary source of care when parents are working or attending school.

Play and Learn groups have become a major support for caregivers who are part of FFN. Play and Learn groups teach caregivers and parents important information about early childhood development and education. Groups are structured to allow both parent/caregiver and child to learn through play. Play and Learn groups are led by a trained facilitator but strive to provide an informal, warm setting.

Measured outcomes – 2010

- A total of 84 percent of parents/caregivers indicated they had changed a behavior that would lead to increased school readiness in their children, such as reading with them, talking to them, and/or doing activities with them.
- A total of 55 percent of parents/caregivers indicated they were better equipped to increase their child's healthy social-emotional development by attending Play and Learn groups.
- A total of 73 percent of parents/caregivers increased their knowledge of caregiver roles and child behavior and are better equipped to promote healthy and nurturing caregiver-child relationships.

Client story

This success story is presented by a parent and caregiver who participated in a Play and Learn group held at ACAP Child Services in Auburn.

"I am so happy with this program and very appreciative because I have learned so much about the children in my care. I've learned how to share more with them, how to teach them, how to play and help children of different ages."

This success story is presented by a three-year-old who participates in a Play and Learn Group held at Chinese Information and Service Center in Seattle.

"Grandma and I come to Play and Learn, we learn ABC, we sing Twinkle, Twinkle, Little Star in both Chinese and English, and we do projects together. We both make new friends and we have a lot of fun."

Evaluation questions

How was the program expanded with levy funding?

Child Care Resources was contracted to provide the FFN Play and Learn Project: $53,000 was awarded to maintain the expansion and enhancement of the project. Strengthening families funding has allowed program enhancement, including the development of the Play and Learn curriculum for playgroups, the development of a Play and Learn tool kit, and additional training for playgroup facilitators. Expansion involved increasing the number of Play and Learn groups from 55 to 60 groups. This program did not exist in King County before it was identified as a need as part of the planning process for the levy.

Who has been served through this program?

A total of 2,492 unduplicated families (consisting of at least one parent/caregiver and child) were served in 2009 in Play and Learn groups. Over three quarters of the families brought their own child. Of the 21 percent in 2010 that brought another person's child, the caregivers were aunts, uncles, grandparents, childcare workers and siblings. There have been over 6,000 attendees annually (family members).

How effective have services been?

In 2010 review:

- A total of 82 percent of parents/caregivers indicated they had changed a behavior that would lead to increased school readiness in their children, such as reading with them, talking to them, and/or doing activities.
- A total of 61 percent of parents/caregivers indicated they were better equipped to increase their child's healthy social-emotional development by attending Play and Learn groups.
- A total of 71 percent of parents/caregivers increased their knowledge of caregiver roles and child behavior and are better equipped to promote healthy and nurturing caregiver-child relationships.

Of those FFN parents who changed their behavior or felt less isolated, the outcome was stronger for participants who attended 37 or more times and for participants who completed the survey form in a language other than English.

Lessons learned

- The FFN Play and Learn Project is highly effective as a way to reach into communities and minimize isolation of young parents.
- Strong effort is required to refine and ensure that Play and Learn is culturally appropriate.

Are any changes in the program model anticipated?

No changes are anticipated.

Strategy 4, Activity 6
Family Treatment Court

Objective: Enable at-risk families to thrive by promoting family stability and child development.

Activity 4.6: Provide treatment for parents involved with the King County Family Treatment Court (FTC) for Child Dependency Cases.

Agencies funded: King County Superior Court FTC Parent to Parent Program

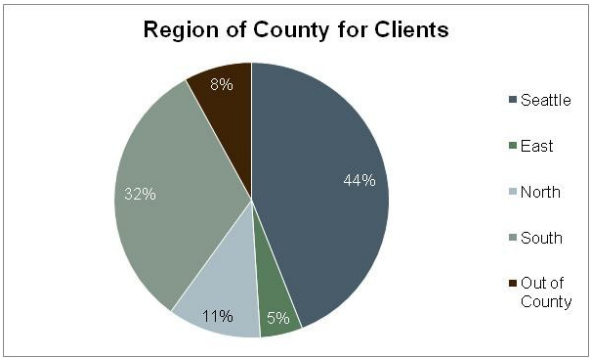
Performance 1/1/2009 – 12/31/2010

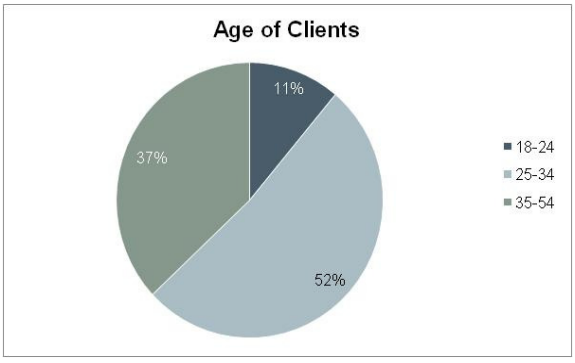
- A total of 54 clients were served in FTC in 2009.
- A total of 26 (of the 54) were new in 2009, received complete intakes, and enrolled in a treatment plan.
- A total of 26 clients left the program and 28 continued on into 2010.
- A total of 45 of the clients are female (83 percent).
- A total of 86 percent of clients were unemployed at intake and 60 percent had no permanent address at intake.

Services provided

The FTC is an alternative to regular dependency court and is designed to improve the safety and well being of children in the dependency system by providing parents access to drug and alcohol treatment, judicial monitoring of their sobriety and individualized services to support the entire family. It started in August 2004.

The FTC integrates substance abuse treatment and increased accountability into the dependency process. It is expected that parents will remain in the FTC between 18 months and two years. The court's first preference is always to help make families whole or to find children a stable environment with their own relatives. If a parent is unable to engage in services or maintain sobriety, the court seeks a prompt, permanent solution for the children. The FTC follows the principles of therapeutic courts and incorporates these evidenced-based strategies by asking parents to enter the program voluntarily and agree to increased court participation, chemical dependency treatment and intense case management in order to reunite with their children.





Measured outcomes – 2009

The measured outcomes are how many clients met their court-mandated treatment goals.

- A total of 26 clients left the program in 2009; 23 had met treatment goals and completed their plans (88 percent).
- The average length of time in the program is 18 months. A complete outcomes evaluation will be completed during 2010.

Client story

Jeri entered FTC in 2008 at age 35, in the middle of her third dependency for the same child. She entered with an active addiction to cocaine and opiates, a history of prostitution and incarceration, and chronic health problems that included bipolar disorder. She was a victim of domestic violence, including physical, emotional and sexual abuse. Her seven-year-old child was exhibiting behavior problems and was living in a foster home. Jeri had been struggling with addiction since age 16. She had no medical insurance.

Jeri was actively using during her first five months in FTC and missed many of her court hearings. The FTC team helped Jeri get medical coverage and find treatment. Jeri entered detoxification treatment in March, but could not get an inpatient bed on her release. She relapsed, but stayed in touch with the team, who help her re-enter detox again in April, this time with an available inpatient bed date.

Jeri has been clean and sober since April 2009. She has found clean and sober housing, is stable on psychotropic medication, and has sought assistance for her chronic health problems. She has become a peer leader, often leading the FTC peer support groups and acting as a mentor for those new to the program. She has stayed connected with her son and will be receiving family counseling with her son along with Family Support Preservation Services to stabilize their relationship upon his return home.

Evaluation questions

How was the program expanded with levy funding?

The levy funds three positions: Program Supervisor, Court Specialist, and Court Appointed Special Advocate (CASA) Supervisor. The Program Supervisor is responsible for overall management of the FTC, while the Court Specialist is responsible for data management and court duties. The CASA Supervisor oversees CASA volunteers who advocate as a neutral party for the best interest of the child(ren).

Who has been served through this program?

- Most FTC participants are female (82%). Families enter the program with multiple needs, including chemical dependency, domestic violence, mental health concerns, and lack of stable housing.
- As of December 2009, 86 percent of parents were unemployed upon entering FTC and 60 percent were without permanent residence.
- Clients include 33 percent over the age of 35.

How effective have services been?

- A total of 26 clients left the program in 2009; 23 had positive outcomes and met treatment goals (88 percent).
- Average length of time in the program is approximately 18 months.

- Complete outcomes evaluation due in 2010.

Lesson Learned

- The program is very effective at creating positive treatment outcomes for parents, giving them the opportunity to reconcile with their families.
- The FTC is taking in clients that are more difficult. Policy has been opened up to include more mental health issues or co-occurring disorders. The FTC should include felonies on a case by case basis.
- Most staff members are busy delivering services, leaving little time for outreach and advocacy with new potential clients.

Are any changes in the program model anticipated?

There are now four levels of treatment plans established. The original policy was for custodial parents. Increasingly, the program is getting more referrals for both parents, including non-custodial parents. Staff would like to increase fathers' involvement in particular.